

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County..... Balto

City or town..... Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
315 Riverside Drive

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Balto

City or town..... Essex  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 315 Riverside Drive  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Margaret M. Abraham

### 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Female White Married

6. (b) Name of husband or wife..... 6. (c) If alive, give age..... years

Frederick W. Abraham

7. Birth date of deceased (mo., day, yr.)..... July 4<sup>th</sup> 1889

8. AGE: Years..... Months..... Days..... It less than one day..... hrs. .... min.

58 8 23

9. Birthplace..... Balto. Md.  
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... At Home

12. Name..... Chas. Holland

13. Birthplace..... Holland

14. Maiden name..... Matilda (Unknown)

15. Birthplace..... Balto. Md.

16. Informant..... Mrs. De Jong

Address..... 545 S. 45<sup>th</sup> St.

17. Burial, cremation, or removal, Which?..... Date thereof..... (month) (day) (year)

Burial 3/31/48

Cemetery or crematory..... Oak Lawn

Location..... Eastern Ave. Extended

18. Funeral director..... William Cook Inc.

Address..... 1217 St. Paul St.

19. Date rec'd by registrar..... 3/29 1948 Dr. Nedrud Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 27 19 48 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 48 to March 27 19 48 and that I last saw him alive on March 27 19 48

Immediate cause of death..... Coronary Thrombosis DURATION 1 day

Due to..... Hypertension 10 years

Due to..... arterio-sclerosis 10 years

Other conditions..... Cerebral Thrombosis 6 months

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. A. Jacobs M. D. or other

Address..... 617 North 2nd Rd Date signed..... 3/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02440

Reg. Dist. No. 35-

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural near Freeland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 52 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Rural near Freeland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3 mi. West  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Emory Webster Alban.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.  
 6. (b) Name of husband or wife Ida Bailey Alban.  
 7. Birth date of deceased (mo., day, yr.) April 3, 1868.  
 6. (c) If alive, give age 83 years  
 8. AGE: Years 79 Months 11 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Freeland, Md.  
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired.

12. Name Joseph F. Alban.

13. Birthplace Balto., Md.

14. Maiden name Julia Gardner.

15. Birthplace Md.

16. Informant Mrs. Ida Alban.

Address Freeland, Md., R. D.

17. Burial Date thereof March 13, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or New Freedom.

Location New Freedom, Penna.

18. Funeral director Jacob Hartenstein

Address New Freedom, Pa.

19. Mar 11 1948 Chester S. Eppert  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1948 at 5:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 1947 to Mar. 10 1948  
 and that I last saw him alive on Mar. 9 1948

Immediate cause of death Cerebral Thrombosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

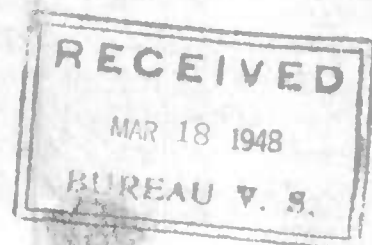
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. M. France

Address Parkton, Md. Date signed 3/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02441

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County BALTO County  
 City or town KINGSVILLE MD CHAPMAN RD.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTO  
 City or town KINGSVILLE MD  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. CHAPMAN RD.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

CLAUDIUS

## 3. (b) Social Security Number

No

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife MARY C. ANDERSON  
NEE SCHAFER 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) JUN. 20, 1873

8. AGE: Years 74 Months 9 Days 8 If less than one day  
 .... hrs. .... min.

9. Birthplace BROOKLYN, MD.  
 (Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business

12. Name CHARLES V. ANDERSON13. Birthplace MD14. Maiden name JURUS SPEARS15. Birthplace MD.16. Informant MRS. MARY C. ANDERSON - (WIFE)Address KINGSVILLE, MD.

17. BURIAL Date thereof 3/31/48  
 (Burial, cremation, or removal. Which?) (month)/(day) (year)

Cemetery or crematory PARKWOODLocation BALTO. CO. MD.18. Funeral director Wm. J. TICKNERT & SONS INC.Address BALTO. MD.

19. 3/30 Dr. A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1948, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 28, 1943 to March 28, 1948  
 and that I last saw him alive on March 27, 1948

Immediate cause of death Coronary Sclerotic sys  
Failure  
Heart disease

DURATION

1 Mo.

Due to General  
arteriosclerosis  
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D.  
York, Md. M. D. or other  
 Address..... Date signed 3/28/48

Wm J. Tickner & Sons  
North. & Penna. Ave.  
Balt 17, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46g

02442

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Kingsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 daysHospital, institution, or street address where death occurred:..... (multi-tened)How long in hospital or institution?..... 0

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Ohio County..... FranklinCity or town..... Columbus

(If outside city or town limits, write RURAL and give nearest town)

Street No. .... 2274 Club Road - Upper Arlington

(If rural, give LOCATION)

2.(a) If veteran, name war..... none

## 3. (a) FULL NAME

Howard Royston Anderson

## 3. (b) Social Security Number

290-03-2217

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife..... Hazel F. Anderson7. Birth date of deceased (mo., day, yr.)..... Nov-4-18866.(c) If alive, give age..... 52 years8. AGE: Years..... 61 Months..... 4 Days..... 20 If less than one day..... hrs..... min.....9. Birthplace..... Crestlinton-Md

(Town, county, and state)

10. Usual occupation..... Coal Operator11. Industry or business..... Pitt-Randolph Co12. Name..... Howard C. Anderson13. Birthplace..... Kent Co. Md14. Maiden name..... Mary S. Leary15. Birthplace..... Kent Co. - Md16. Informant..... Mrs. Hazel F. Anderson - (wife)Address..... Columbus - Ohio17. Burial, cremation, or removal, which?..... Burial Date thereof..... 3-24-48

(Burial, cremation, or removal, which?)..... (month) (day) (year)

Cemetery or crematory..... Green LawnLocation..... Columbus - Ohio18. Funeral director..... Stewart-Morris Co.Address..... 1024 W North St - Balto.19. March 24 19 48 A. W. Hedrick

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 24 19 48 at 1 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 19 48 to March 23 19 48and that I last saw him..... alive on March 21 19 48Immediate cause of death..... metastatic Carcinoma DURATION.....Due to..... Carcinoma of pancreas

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Multiple metastases in pleuralCavities - One removed for section Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Armin Fried M. D. or other.....Address..... #316 Medical Arts Bldg Date signed..... Mar 24/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02443

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since March 2, 1948Hospital, institution, or street address where death occurred:  
Sheppard & Enoch Pratt HospitalHow long in hospital or institution? Admitted: March 2, 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania CountyCity or town Waynesboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. 120 West 2nd Street  
(If rural, give LOCATION)2.(a) If veteran, name war WW II ✓

## 3. (a) FULL NAME

EARL HEINTZELMAN BENEDICT

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 22, 19098. AGE: Years 38 Months 9 Days 3 If less than one day  
hrs. min.9. Birthplace Franklin County, Pa.  
(Town, county, and state)10. Usual occupation Salesman11. Industry or business Tool company12. Name Daniel G. Benedict13. Birthplace Maryland14. Maiden name Laura Heintzelman15. Birthplace Pennsylvania16. Informant Hospital recordsAddress Sheppard-Pratt Hosp., Towson 4, Md.17. Burial Date thereof Mar. 27, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Green Hill CemeteryLocation Waynesboro, Franklin Co., Pa.18. Funeral director POE FUNERAL HOMEAddress WAYNESBORO, PENN.19. (Date rec'd by registrar) 19 3/25/48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 48 at 5:10 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 2 19 48 to March 25 19 48  
and that I last saw him alive on March 24 19 48Immediate cause of death Myocarditis DURATION 3wks +Due to Hypertension Unk.

Due to

Other conditions Dementia Praecox - Paranoid 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry M. Murdock M. D. or otherAddress Sheppard-Pratt, Towson, Md. Date signed 3/25/48

MARGIN RESERVED FOR BINDING

VS AM5 9-45-15M

VS AM5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 11 1948  
BUREAU V. S.

RECEIVED  
MAY 11 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6218 Liberty Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6218 Liberty Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Virginia D. Bohannon

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife James H. Bohannon7. Birth date of deceased (mo., day, yr.) August 1, 1863

6. (c) If alive, give age..... years

8. AGE: Years 84 Months 7 Days 30 If less than one day  
.....hrs. ....min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Wm. S. Parrish13. Birthplace Virginia14. Maiden name Catharine Rayner15. Birthplace Virginia16. Informant Mrs. Virginia HarrisonAddress 6218 Liberty Rd Wdln17. Burial Date thereof April 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Parrish CemeteryLocation Woodlawn 2d18. Funeral director E. Willis HamoreauAddress 4510 Liberty Hgts Ave19. 3/31 88 D.W. Hedrick  
(Date rec'd by registrar) 19..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 31 19 48 at 5:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 26, 1924 19..... to Mch 31 19 48  
and that I last saw him alive on Mch 31 19 48Immediate cause of death Cerebral Hemorrhage

DURATION

5 days

Due to.....

Due to.....

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury 1 Injured at work?23. SIGNATURE No A. Lumbacher M. D. or otherAddress 12 E. Eager St Balto Date signed Mch 31/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No. 38

1. PLACE OF DEATH:  
 (a) Baltimore City, Maryland  
 (b) Street address 2624 Hillcrest Ave.  
 (c) Hospital or institution:  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Md. (b) County Balto.  
 (c) City or town Baltimore  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 2624 Hillcrest Ave.  
 (If rural give location)  
 (e) Citizen of foreign country? (Yes or No)  
 If yes, name country.

3 (a) FULL NAME JOHN L. BOHNE

3 (b) If veteran, name war No 3 (c) Social Security Account No. 216-03-1042

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced widower

6 (b) Name of husband or wife Marie E. Bohne 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16th, 1880

8. AGE: Years 67 Months 5 Days 6 If less than one day hr. min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business C & C Co.

12. Name Henry Bohne  
 13. Birthplace Unknown

14. Maiden Name Louise Pfeinig  
 15. Birthplace Unknown

16 (a) Informant Mrs. E. Louise Miller  
 (b) Address 2624 Hillcrest Ave.

17 (a) burial (b) Date thereof 3/25/48  
 (Burial, cremation, or removal) (month) (day) (year)  
 (c) Cemetery or crematory Baltimore  
 Location Baltimore, Md.

18 (a) Funeral director Lanah Funeral Home  
 (b) Address 7401 Belair Road

19 (a) 3/24/48 (b) G. M. Breen  
 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 22nd 19 48, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1948 to 3/22 1948, and that I last saw him alive on 3/20 1948.

Immediate cause of death Coronary thrombosis Duration 3 w.

Due to arteriosclerotic

Due to cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Arnold G. Groat M. D.

Address 8100 Harford Rd. Date signed 3/23/48

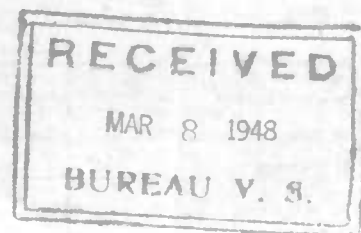
Reg. Diat. No. 4-

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Arbutus</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>27 yrs.</u> Hospital, institution, or street address where death occurred: <u>1319 North Ave</u> How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Arbutus</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>1319 North Avenue</u> (If rural, give LOCATION) 2(a) If veteran, name war <u>World War I</u>	
3. (a) FULL NAME <u>William Charles Brauer</u>		3. (b) Social Security Number <u>213-05-2898</u>	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>	
6. (b) Name of husband or wife		MEDICAL CERTIFICATION	
7. Birth date of deceased (mo., day, yr.) <u>March 1, 1895</u>		20. DATE OF DEATH <u>March 5, 1948</u> at <u>8:30 P.M.</u>	
8. AGE: Years <u>53</u> Months <u>4</u> Days <u>4</u> It less than one day _____ hrs. _____ min.		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____ and that I last saw him _____ alive on _____ 19____	
9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state)		Immediate cause of death <u>Coronary occlusion</u>	
10. Usual occupation <u>Machinist Helper</u>		Due to _____	
11. Industry or business <u>Pittsburgh Plate Glass Co.</u>		Due to _____	
MOTHER	12. Name <u>William J. Brauer</u>	Other conditions _____	
	13. Birthplace <u>Maryland</u>	(Include pregnancy within 3 months of death)	
	14. Maiden name <u>Katherine Schmidt</u>	Major findings of operations _____	
	15. Birthplace <u>Maryland</u>	Date of op. _____	
16. Informant <u>Miss. Amelia C. Brauer</u> Address <u>1319 North Ave. Arbutus</u>		Autopsy results _____	
17. <u>Burial</u> Date thereof <u>3-8-48</u> (Burial, cremation, or removal. Which?) (Month) (Day) (year)		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
Cemetery or crematory <u>Louisa Park</u>		22. VIOLENCE: If death was due to external causes, fill in the following:	
Location <u>Baltimore Maryland</u>		Accident, suicide, or homicide _____ Date of _____	
18. Funeral director <u>George F. Skwal</u>		Where did injury occur? _____ (City or town) _____ (County) _____ (State)	
Address <u>4101 Frederick Ave. Balto., Md.</u>		Injured at home, farm, industry, public place (where?) _____	
19. <u>Mar 6 48</u> <u>De Kieffer</u> (Date rec'd by registrar) Registrar		Means of injury _____ Injured at work? _____	
		23. SIGNATURE <u>Geo. De Kieffer</u> <u>De Kieffer</u> M. D. or other _____	
		Address <u>1010 Lehigh Ave</u> Date signed <u>3-6-48</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 2 mos., 18 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium  
 How long in hospital or institution? 1 yr., 2 mos., 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Mont. Co.  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 213 Buffalo Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Mary Ellen Bryant

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Theodore K. Bryant7. Birth date of deceased (mo., day, yr.) June 22, 1874

8. AGE: Years 73 Months 8 Days 27 If less than one day  
 hrs. min.

9. Birthplace Jacksonville, New York  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William Dederer13. Birthplace New York, New York14. Maiden name Eliza Nourse15. Birthplace Danby, New York16. Informant Mary E. BryantAddress 213 Buffalo Ave., Takoma Pk., Md.17. Burial Date thereof Mar. 23, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lakeview CemeteryLocation Ithica, New York18. Funeral director J. Arthur WaltersAddress 254 Carroll St., N.W., Takoma Pk.,19. Mar. 20, 19 48 Earl T. Webster, D.O.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20, 19 48, at 4:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 2, 19 47, to March 20, 19 48  
 and that I last saw her alive on March 20, 19 48

Immediate cause of death Pulmonary Tuberculosis  
Tubercle Bacilli

Due to  
 Due to  
 Other conditions None

(Include pregnancy within 3 months of death)  
 Major findings of operations No operation  
 Date of op.

Autopsy results No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer m.d.  
 M. D. or other  
 Address Mt. Wilson, Md. Date signed 3/20/48

Rec'd - 3-20-48 Dr. E. E. Nichols - R. M. W.

RECEIVED

MAR 22 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02448

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Masonic Home

How long in hospital or institution? 2 yrs & 8 months

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2845 W. Lafayette Ave  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Silas Eugene Bucker

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Ella Hiltner

7. Birth date of deceased (mo., day, yr.) Dec 25th 1969 6. (c) If alive, give age years

8. AGE: Years 78 Months 2 Days 20 If less than one day hrs. min.

9. Birthplace Fondelsburg, Balto. Co.  
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business

12. Name Hoah Lewis Bucker

13. Birthplace Baltimore Md

14. Maiden name Elizabeth Warren

15. Birthplace Pennsylvania

16. Informant Laura M. Schroeder

Address Masonic Home Cockeysville

17. Burial, cremation, or removal. Which? Burial Date thereof Mar 19-48  
(month) (day) (year)

Cemetery or crematory Landon Pk

Location Baltimore Md

18. Funeral director Wm. Cole

Address St. Paul & Preston St.

19. Mar 17 19 48 Laura M. Schroeder  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 16 19 48 11 58 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 47 to Mar 16 19 48 and that I last saw him alive on Mar 16 19 48

Immediate cause of death

DURATION

Myocardiac Insufficiency 3 days

Due to Diabetes Mellitus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter L. Kees M.D.

Address Cockeysville Md Date signed 3/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED IN ORIGINAL THIS DOCUMENT

STATE OF CALIFORNIA

RECEIVED  
MAR 18 1948  
BUREAU V. S.

RECEIVED  
MAR  
BUREAU V. S.

RECEIVED  
MAR 18 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
county shown on:

FILM No. G 115 APR 23 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

02449

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Maryland Baltimore

City or town Franklinville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Franklinville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

Addie J. Burke

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John A. Burke

7. Birth date of deceased (mo., day, yr.)

Dec 21, 1867

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years 80 Months 2 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace

Housewife  
(Town, county, and state)

10. Usual occupation

Wid.

11. Industry or business

John Gordon

12. Name

Fried.

13. Birthplace

Catherine Chlaney

14. Maiden name

Pay

15. Birthplace

Miss Clifton Bowling

16. Informant

Franklinville Md.

17. Address

Burial

18. Date thereof

Mar. 13/48  
(month) (day) (year)

19. Cemetery or crematory

Franklinville & Presby. Teran

20. Location

Baltimore Co., Md.

21. Funeral director

Chas. E. Gross

22. Address

Benson, Md.

23. Date rec'd by registrar

3/12 48

24. Registrar

O'Fowood

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1948 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 3 1946 to March 11 1948

and that I last saw him live on March 10 1948

Immediate cause of death Congestive Heart Failure DURATION 4 yrs

Due to Intermittent Heart Disease 3 yrs

Due to \_\_\_\_\_

Other conditions Graves Disease 20 yrs

Carcinoma of breast 2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Ante-mortem results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Clifford F. Hudson, M.D.

Frank Md. M. D. or other \_\_\_\_\_

Date signed 3/12/48

69 / 1947  
0801

RECEIVED  
MAR 16 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02450

Reg. Dist. No.

38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Jackson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty BaltimoreCity or town Jackson  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Charles Malcolm Canedy

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

N

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Marcia Livermore

7. Birth date of

deceased (mo., day, yr.)

1/12/1888

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59113

hrs.

min.

9. Birthplace

New York  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 3/16

(Date rec'd by registrar)

19. 48R.W. Hebrich

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 1519. 48

at

7:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19. 48 to March 15 19. 48and that I last saw him alive on March 14 19. 48Immediate cause of death Carcinoma of  
ascending colon  
with metastases to  
liver

DURATION

Due to

Due to

Other conditions

Jaundice  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James R. Karns, MD  
M. D. or otherAddress 700 Cathedral StDate signed Mar. 16, 1948

To be called for

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH

County Baltimore - 19  
 City or town Spawton Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:  
Box 305A - Creek Rd.  
 How long in hospital or institution? none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County in #1  
 City or town in #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. World War I  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

WILLIAM RALPH CHARLTON

## 3. (b) Social Security Number

213-07-7206

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Malissa Charlton  
 6. (c) If alive, give age 37 years  
 7. Birth date of deceased (mo., day, yr.) Sept. 24. 1896  
 8. AGE: Years 51 Months 5 Days 25 If less than one day hrs. min.

9. Birthplace Baltimore - md.  
 (Town, county, and state)  
 10. Usual occupation operator - draw Bridge  
 11. Industry or business machinist  
 12. Name Thomas A. Charlton  
 13. Birthplace Johnstown, Pa.  
 14. Maiden name Burnie Catherine Hutmacher  
 15. Birthplace Richmond, Va.

16. Informant Malissa Charlton  
 Address Box 305A Creek Rd - Sp. Pt.  
 17. Bureau Date thereof 3/27/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore  
 Location Baltimore  
 18. Funeral director Leonard J. Buck  
 Address 5305 Harford Road  
 19. March 22 1948 G. W. Heger Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948 at 4 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 47 to March 19 48  
 and that I last saw him alive on March 19 48  
 Immediate cause of death Coronary occlusion  
Arteriosclerosis  
& angina pectoris

## DURATION

1 day.6 mo.

Due to Arteriosclerosis  
 Due to & angina pectoris  
 Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations   
 Date of op.

Autopsy results   
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  Date of   
 Where did injury occur?  (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)   
 Means of injury  Injured at work?

23. SIGNATURE Louis N. Hallin MAR 19 1948  
6908 N. Pt. Rd M. D. or other  
 Address Barto Date signed 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02451

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town 220 Muslock Rd. Rodgers Forge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 59 Burke Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Louise Chase

## 3. (b) Social Security Number

215-032476A

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 18738. AGE: Years 75 Months 2 Days 2 If less than one day hrs. min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Saleslady

## 11. Industry or business

12. Name Franklin Benjamin Chase13. Birthplace Annapolis, Md.14. Maiden name Julia Farley15. Birthplace Ireland16. Informant Helen M. GladeAddress 59 Burke Ave. Towson, Md.17. Obit Date thereof Mar 9 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Vincent'sLocation Baeto. Ind.18. Funeral director Henry M. Jenkins & SonsAddress McCallon Orchard St.19. March 8 48 A.W. Haynes  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7 Mch 19 48, at 3 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 37, to 7 Mch 19 48, and that I last saw him alive on 7 Mch 19 48.Immediate cause of death Cerebral OcclusionDue to Arterio-sclerosisDue to Cardio-Vascular Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H. Keir M.D.Address 6701 York Rd. Baltimore Date signed 8 Mch 48

Dr. Chas R. Ruer  
6701 York Rd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02453

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred

33 Admiral Blvd.

How long in hospital or institution?

none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 33 Admiral Blvd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Robert D. Colbert

## 3. (b) Social Security Number

?

4. Sex

M

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Catherine Colbert  
(nee Koeing)

6. (c) If alive, give age - years

7. Birth date of

deceased (mo., day, yr.)

1-28-1879

8. AGE:

Years

Months

Days

If less than one day

6915

hrs.

min.

9. Birthplace

Maryland  
 (Town, county, and state)

10. Usual occupation

Rail Road Conductor

11. Industry or business

MOTHER

FATHER

12. Name

Thomas Colbert

13. Birthplace

Ireland

14. Maiden name

Margaret Crowley

15. Birthplace

Ireland

16. Informant

Thomas Colbert

Address

33 Admiral Blvd.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

3-6-48  
 (month) (day) (year)

Cemetery or crematory

Oak Lawn Cem.

Location

Eastern Ave. Exp.

18. Funeral director

Lilly & Zeiler Inc.

Address

403 S. Wolfe St. (31)

19.

(Date rec'd by registrar)

19.

3/8 St. A.W. Hedrick  
DM Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 19 48 at 10:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. - 19 45 to Feb. 19 48and that I last saw him alive on Feb 3 19 48

Immediate cause of death

Chronic Myocarditis

DURATION

5 yrs.

Due to

A-S-C-V-Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide None Date ofWhere did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.B. Davis  
St. Michaels

M. D. or other

Date signed 3/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age

and birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 114 APR 6 1948

FILM No. G 114 MAR 30 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: 345 Della Ave. Catonsville.  
 County..... Catonsville.  
 City or town..... Balto. Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... about 2 yrs.  
 Hospital, institution, or street address where death occurred:  
 345 Della Ave. Catonsville, Md.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 345 Della Ave. Catonsville 18 Md.  
 (If rural, give LOCATION)

2.(c) If veteran, name war.....

3.(a) FULL NAME

Paisi Woods Craig

3.(b) Social Security Number

4. Sex

F.

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Alfred Craig

7. Birth date of deceased (mo., day, yr.)

May 18, 1908 1900

5.(c) If alive, give age. 54 years

8. AGE: 47 years

24 yrs

Months

10

Days

3

It less than one day

hrs.

min.

9. Birthplace

Essex Co. Va.

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

MOTHER FATHER

12. Name

William H. Cook

13. Birthplace

Essex Co. Va.

14. Maiden name

Hellen Wiggs

15. Birthplace

Essex Co. Va.

16. Informant

Alfred Craig

Address

345 Della Ave. Catonsville Md

17.

Burial

Date thereof

3/25/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Auburn

Location

West Port Balto. Md

18. Funeral director

Metropolitan Fun. Home Inc.

Address

927. n. Mount St.

19.

March 27 48

Date rec'd by registrar

R. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 1948 at 345 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct-30-47 1947 to 3-21st 1948

and that I last saw her alive on 3-21st 1948

Immediate cause of death

Mitral Insufficiency

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

C. F. Maloney

M. D. or other

Address

Catonsville Md

Date signed

3/26/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

02455

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 daysHospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 N. Ann Street  
(If rural, give LOCATION)2.(a) If veteran, name war WW 2

## 3. (a) FULL NAME

MICHAEL C. CZERWINSKI

## 3. (b) Social Security Number

252-38-9831  
Unknown

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Divorced

6. (b) Name of husband or wife Divorced7. Birth date of deceased (mo., day, yr.) 8-4-19048. AGE: Years Months Days If less than one day  
43 6 27 hrs. min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Peter Czerwinski13. Birthplace Poland14. Maiden name Bertha Zycha15. Birthplace Poland16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Md.17. Burial Date thereof 3/4/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National Cemetery  
Baltimore, MarylandLocation Howard N. Blighs 218. Funeral director Howard Bligh Funeral HomeAddress 4914 Belair Rd., Baltimore, Md.19. 3/3 48 A W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 19 48 at 8:20 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 18, 19 48, to March 1, 19 48  
and that I last saw h. in alive on March 1, 19 48Immediate cause of death  
Tuberculosis, pulmonary, far adv.  
active

## DURATION

4 Months  
plus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. H. USDIN, M.D. M. D. or otherAddress V. A. H. FORT HOWARD, MD. Date signed 3-2-48

PLEASE WRITE PLAIN, WITH UNFADING INK. Supply every item of information clearly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02456

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 11 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove 1 year, 11 days  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George  
 City or town Berwyn P. O., Daniels Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 55 Fox Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

THOMAS F. DEAN

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mary Nolly  
 7. Birth date of deceased (mo., day, yr.) February 11, 1871  
 6. (c) If alive, give age 71 years  
 8. AGE: Years 77 Months 1 Days 20 It less than one day hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation Tree surgeon, odd jobs

11. Industry or business Tree repair, miscellaneous

12. Name Benjamin Dean

13. Birthplace Maryland (Eastern Shore)

14. Maiden name Harriett Andrews

15. Birthplace Maryland (Eastern Shore)

16. Informant Hospital records

Address Catonsville 28, Maryland

17. Removal Date thereof Mar 31, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Riverdale md.

Location

18. Funeral director W. W. Chambers company

Address Riverdale Maryland

19. April 1 1948 W. E. Harris  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31 19 48 at 9:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Berehal Lemonage DURATION

Due to Coronary vascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

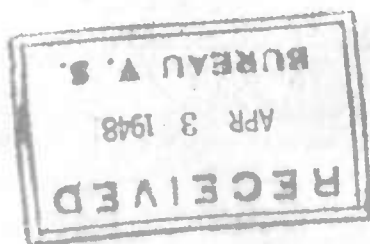
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. W. E. Harris Dr. W. E. Harris

Address 1010 Leckman Date signed 3-31-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02457

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County ParkvilleCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2900 Taylor Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ParkvilleCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2900 Taylor Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Charles Dei Sr.

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Clara B.

7. Birth date of deceased (mo., day, yr.)

Feb 22-1874

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7415

hrs.

min.

9. Birthplace

Baltimore Md  
(Town, county, and state)

10. Usual occupation

Retired contractor

11. Industry or business

MOTHER FATHER

12. Name

Martin Dei

13. Birthplace

Germany

14. Maiden name

Rosina Sauerhier

15. Birthplace

Germany

16. Informant

Mrs. Clara B. Dei

Address

2900 Taylor Avenue

17.

(Burial, cremation, or removal. When)

Date thereof

3/30/48  
(month) (day) (year)

Cemetery or crematory

Parkwood

Location

Baltimore

18. Funeral director

J. F. Fick

Address

5305 Maryland Road

19.

(Date rec'd by registrar)

3/29/48J. M. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 27, 1948, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 15, 1942, to March 27, 1948and that I last saw him alive on March 26, 1948

Immediate cause of death

Chronic myocarditis

DURATION

15 years

Due to

Arteriosclerosis  
Rheumatic heart disease

Due to

Other conditions

Atypical pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. V. Harbold M.D.

M. D. or other

Address 4706 Harford Road Date signed 3-27-48  
Baltimore

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

02458

## 1. PLACE OF DEATH:

County BALTO.  
 City or town 5313 EDMONDSON AVE  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? HOOD NURSING HOME  
 Hospital, institution, or street address where death occurred: 3 YRS.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County ---  
 City or town BALTO.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5313 EDMONDSON AVE  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

MARTHA S. DIAMOND

## 3. (b) Social Security Number

No

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WIDOW

6. (b) Name of husband or wife

JOSEPH B. Diamond

7. Birth date of deceased (mo., day, yr.)

OCT. 7, 1862

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

85

5

20

hrs.

min.

9. Birthplace

CAROLINE CO., Va.  
(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

PARKSON CHENAU

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

MRS. CHAS. H. TAWNEY

Address

3903 WALNUT AVE

17.

(Burial, cremation, or removal, Which?)

Date thereof

BURIAL

3/31/48  
(month) (day) (year)

Cemetery or crematory

PARKWOOD

Location

BALTO. CO., MD.

18. Funeral director

Wm. T. Tickner &amp; Sons

Address

BALTO., MD.

19.

(Date rec'd by registrar)

19

48

V. E. Harry

Registar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

3/27

19

48

at

10 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-20

19

48

to

3-27

19

48

and that I last saw him alive on

Mar 27

19

48

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

Neurological Lesions

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

V. E. Harry

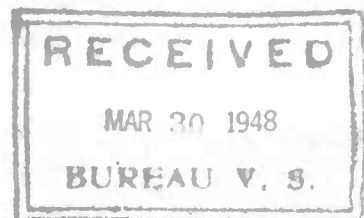
M. D. or other

Address

Date signed

3/29

Inf. by phone: No home - lived with daughter - informant  
4/9/48-ams.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47a

02459

## CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

## 1. PLACE OF DEATH:

County *Baltimore*City or town *Sparrows Point*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*George Roehereiner*

## 3. (b) Social Security Number

4. Sex *Male*5. Color or race *White*6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Christiana Schmidt*7. Birth date of deceased (mo., day, yr.) *December 2, 1858*8. AGE: Years *89* Months Days If less than one day9. Birthplace *Germany*  
(Town, county, and state)10. Usual occupation *Retired farmer*

11. Industry or business

12. Name *Nickolas Roehereiner*13. Birthplace *Germany*14. Maiden name *Anna M. Thomas*15. Birthplace *Germany*16. Informant *Mr. John Roehereiner*Address *537 E. St. Sp. Pt.*17. *Burial* Date thereof *3/16/48*  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Oakland*Location *Eastern Ave*18. Funeral director *John Flenny Inc*Address *715 Light St.*19. *3/5* 19 *48* *A-W Hedrick*  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* County *Balt*City or town *Sparrows Point*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *428 7th*  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH *March 2* 19 *48*, at *1* P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *January 15* 19 *48*, to *March 2* 19 *48*, and that I last saw him alive on *March 1st* 19 *48*Immediate cause of death *Carcinoma of Lung*

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *D. R. Jones, M.D.*

M. D. or other

Address *520 2nd St. Sp. Pt.* Date signed *5/4/48*

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02460

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Woodlawn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2043 Featherbed Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Pauline Dorl

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow8. (b) Name of husband or wife John Dorl

7. Birth date of

deceased (mo., day, yr.)

June 8, 1870

6. (c) If alive, give age ----- years

8. AGE:

Years

Montha

Days

If less than one day

77910

hrs.

min.

9. Birthplace

Crakow

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

??

MOTHER

14. Maiden name

Teresa Finke

15. Birthplace

Unknown

16. Informant

Elizabeth Dorl

Address

2043 Featherbed Lane

17.

BurialDate thereof 3-23-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Cathedral

Location

Baltimore Maryland

18. Funeral director

E. E. Swarth Armacost

Address

3911 Liberty Heights Ave.

19.

3-22-48

19

48Q. W. H. H. H.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 20

19

48 at 9:48 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1

19

42 toMarch 20 19

and that I last saw her alive on

March 10

19

Immediate cause of death

Chronic Myocardial Degener.

DURATION

10 yrs.

Due to

Senility

Due to

Other conditions

Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

No operation

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joshua H. Armacost MD

M. D. or other

Address

6919 Windsor Hill Rd.

Date signed

Mar 21Baltimore - 7 1948

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02461

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore, MarylandCity or town Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Spring Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)Street No. Spring Ave  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Mable Lettie Durm

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Laurence7. Birth date of deceased (mo., day, yr.) January 7, 18688. AGE: Years 80 Months 2 Days 14 If less than one day hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Charles Clark  
13. Birthplace N.H.14. Maiden name Olive Lunt  
15. Birthplace Boston, Mass.16. Informant Mrs. Morine Hohrein  
Address Halethorpe, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Thursday Mar 25  
(month) (day) (year)Cemetery or crematory Loudon Park CemeteryLocation Baltimore, Maryland18. Funeral director Wm. Cook, Inc.Address 1217 St. Paul Street, Baltimore19. March 22, 1948 A. W. Hoffmann  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948 at 5:25 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1947 to Mar 21 1948  
and that I last saw him alive on Mar. 19 - 48 1948Immediate cause of death Ch. Myocarditis  
with Arterio sclerosisDue to Chronic Colitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Hanson M.D.Address 1711 Selma Ave. Date signed 3/23/48

M. D. or other

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

02462

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 yrs. 2 mos. 9 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 12 yrs. 2 mos. 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1949 N. Patterson Park Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Katherine Eberwein

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife unknown Jacob F.7. Birth date of deceased (mo., day, yr.) November 21, 1879

6. (c) If alive, give age ..... years

8. AGE: Years Months Days If less than one day  
68 4 5 ..... hrs. .... min.9. Birthplace Austria  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Charles Newkam (Newkam)13. Birthplace Austria14. Maiden name Unknown15. Birthplace Austria16. Informant Hospital recordsAddress Catonsville 28, Md.17. Burial Date thereof Mar. 29, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Baltimore CemeteryLocation End of E. North Ave.18. Funeral director Edmund W. Conklin's sonAddress 924 E. Eager St.19. 3/27 19 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 48 at 1:25 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 17 19 36 to March 26 19 48and that I last saw her alive on March 26 19 48Immediate cause of death Gangrene of right foot DURATION 10 daysDue to Diabetes Mellitus indefiniteGeneralized Arterio Sclerosis indefiniteDue to Arterio Sclerotic Heart Disease indefiniteOther conditions Cerebral Accident ? 3 days

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Auto Truck Injured at work?23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville 28, M.D. Date signed 3-26-48

PLEASE WRITE PLAIN, WITH UNFADING INK. Supply every item of information clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02463

## CERTIFICATE OF DEATH

Reg. Dist. No. 84

## 1. PLACE OF DEATH:

County BaltimoreCity or town Sparks (Rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Sparks (Rural)  
(If outside city or town limits, write RURAL and give nearest town)Street No. Falls Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

George Edward Enzor

## 3.(b) Social Security Number

4. Sex

M.

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Sarah Jane Clibborn

7. Birth date of

deceased (mo., day, yr.)

Aug. 12, 1860

8. AGE:

Years

Months

Days

If less than one day

87725

hrs.

min.

9. Birthplace

Sparks Balto Co, Md.  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER  
MOTHER

12. Name

George K. Enzor

13. Birthplace

Balto Co, Md.

14. Maiden name

Sallie Cole

15. Birthplace

Balto Co Md.

16. Informant

Mrs. George E. Enzor

Address

Sparks, Md

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

Mar 11, 1948  
(month) (day) (year)

Cemetery or crematory

Black Rock

Location

Butter Balto Co Md

18. Funeral director

London M. Brooks

Address

Sparks Balto Co Md

19.

March 12, 1948  
(Date rec'd by registrar)1948Carl E. Fritts M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

3-8-

19

48 at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1- 19 40 to 3-8- 19 48and that I last saw him alive on 3-6- 19 48

Immediate cause of death

myocarditischronic decompensatingDue to hypertensionDue to atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

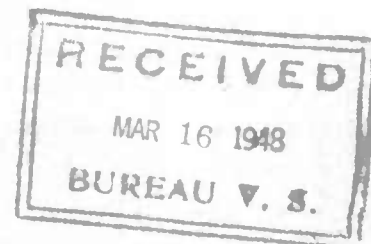
James H. Saffell M.D.Address Reveries home Md Date signed 3-9-48

MARGIN RESERVED FOR BINDING

9-45-15W

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17a

## CERTIFICATE OF DEATH

02464

Reg. Dist. No. 41

1. PLACE OF DEATH: Turner Station Md.

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....BaltimoreCity or town.....Turner  
(If outside city or town limits, write RURAL and give nearest town)Street No. 129 Cypress St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Clinal Benjamin Evans

## 3. (b) Social Security Number

216-20-44044. Sex.....M.5. Color or race.....C

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 4/24/19368. AGE: Years 21 Months 11 Days 11 hrs. 9 min.9. Birthplace.....Baltimore  
(Town, county, and state)10. Usual occupation.....Police

11. Industry or business.....

12. Name.....Hanson Martin Evans13. Birthplace.....Baltimore14. Maiden name.....Clara Cooper15. Birthplace.....Easton Md.16. Informant.....Clara EvansAddress.....129 Cypress St.17. Burial Date thereof March 11 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....Mt Auburn Cemetery

Location.....

18. Funeral director.....Lionard ItalenAddress.....1047 Myrtle Ave.19. March 11, 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH.....3-8-48 19..... at 9:15 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1948 to 3-8-48and that I last saw him alive on 3-8-48 19.....Immediate cause of death.....InanitionDue to.....Disseminated TBCDue to.....Osserous

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Maana of Injury..... Injured at work?.....

23. SIGNATURE.....Arthur J. EvansAddress.....423 New BaltimoreDate signed.....3-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltoCity or town Middle River  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wry Hall Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County BaltoCity or town Middleburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 25 Antietam Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

GRACE A. EVANS

## 3.(b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Harry C. Evans6.(c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) Nov. 29 - 18978. AGE: Years 50 Months 3 Days 1 If less than one day  
hrs. min.9. Birthplace Balto Md.  
(Town, county, and state)10. Usual occupation Homemaker11. Industry or business at home12. Name Charles Evans13. Birthplace Balto14. Maiden name Georgia Shipley15. Birthplace Balto16. Informant Mr. Harry C. EvansAddress 25 Antietam Rd.17. Burial, cremation, or removal. Which? BurialDate thereof Apr. 3 - 1948  
(month) (day) (year)Cemetery or crematory ParkwoodLocation Taylor Ave.18. Funeral director John B. ConnollyAddress 418 Eastern Ave.19. Apr. 2 - 1948 John B. Connolly

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1948 at 11 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 28 1948 to March 30 1948and that I last saw him alive on March 26 1948

Immediate cause of death

Carcinomatosis, generalized DURATION 1 1/2 yrs

Due to

Carcinoma of breast 2 yrs

Due to

Other conditions Hypertensive cardio-vascular disease ?  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

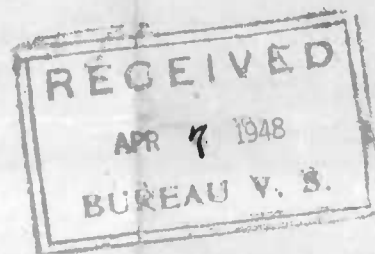
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE DR. G. J. Miller MD M. D. or otherAddress Ridge Rd, Balt-6 Date signed 3/31/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

02467

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH: *Baltimore*  
 County *Halethorpe*  
 City or town *Halethorpe*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *8 years*  
 Hospital, institution, or street address where death occurred:  
*5618 Ashbourne Rd*  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Md.* County *Baltimore*  
 City or town *Halethorpe*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *5618 Ashbourne Road*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME *Nathaniel W. Garley*

3. (b) Social Security Number

4. Sex *M* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *Widower*  
 6. (b) Name of husband or wife *Ida M. Garley*  
 7. Birth date of deceased (mo., day, yr.) *Sept. 5, 1872*  
 5. (c) If alive, give age years

8. AGE: Years *74* Months *6* Days *4* If less than one day  
 min.

9. Birthplace *Petersburg, Va.*  
 (Town, county, and state)  
 10. Usual occupation *Retired Stone Cutter*  
 11. Industry or business *Linedy Memorial Worker*

12. Name *N. L. Garley*  
 13. Birthplace *Va.*  
 14. Maiden name *Margaret J. Wilson*  
 15. Birthplace *Va.*

16. Informant *Mrs. Marguerite V. Heckner*  
 Address *5618 Ashbourne Road*

17. *Burial* Date thereof *3-11-1948*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory *Louisa Park*

Location *Baltimore, Md.*  
 18. Funeral director *J. Howard Strong*  
 Address *3207 W. North Ave.*

19. *Mch 9 1948* Registrar *G. Kieffner*  
 (Date rec'd by registrar)

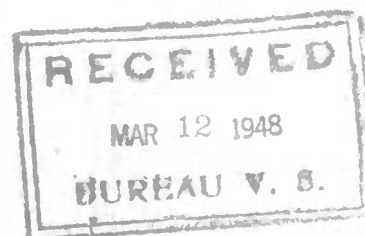
MEDICAL CERTIFICATION  
 20. DATE OF DEATH *March 9 1948* at *1:45* P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*June 14 1946* to *Mar 9 1948*  
 and that I last saw him alive on *Mar 9 1948*

Immediate cause of death  
*Cerebral Embolism* DURATION *2 days*  
 Due to *Arteriosclerotic disease*  
 Due to *Sclerosis* *years*  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE *G. S. Kieffner* M. D. or other  
 Address *2470 West 3rd* Date signed *Mar 9 1948*



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02466

Reg. Dist. No. 32

### 1. PLACE OF DEATH:

County Baltimore  
City or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 0 yrs., 4 mos., 27 days  
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium  
How long in hospital or institution? 0 yrs., 4 mos., 27 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Sydenham Hosp., Orderly Qts.,  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Leo Farnam

### 3. (b) Social Security Number

125-09-5637

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife   
7. Birth date of deceased (mo., day, yr.) July 27, 1902  
6. (c) If alive, give age  years  
8. AGE: Years 45 Months 7 Days 6 If less than one day  hrs.  min.

9. Birthplace Troy, New York  
(Town, county, and state)  
10. Usual occupation Kitchen Worker  
11. Industry or business   
12. Name James Farnam  
13. Birthplace Troy, New York  
14. Maiden name Julia Cavanaugh  
15. Birthplace Troy, New York

16. Informant Leo Farnam  
Address Sydenham Hosp., Orderly Qts., Balto., Md.  
17. Burial Date thereof Mar. 8, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory St. Peter's Cemetery  
Location Troy, New York

18. Funeral director Wm. Newell & Sons  
Address Pikesville, Maryland

19. Mar. 4, 1948 Earl T. Webster  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1948 11:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 1947 to Mar. 4, 1948  
and that I last saw him alive on March 4, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 2 yrs.

Due to Tubercle Bacilli

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operation No operation.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE Stewart S. Shaffer, M.D.

Address Mt. Wilson, Md. Date signed 3/4/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 9 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02468

Reg. Diat. No. 38

### 1. PLACE OF DEATH:

County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
0

How long in hospital or institution? 0

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 605 Bosley Dr  
(If rural, give LOCATION)  
2.(a) If veteran, name war No

### 3. (a) FULL NAME

Eleanor Feast

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife none

7. Birth date of deceased (mo., day, yr.) June-9-1862

8. AGE: Years 85 Months 9 Days 19 It less than one day hrs. min.

9. Birthplace Baltimore md  
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name Samuel Feast

13. Birthplace England

14. Maiden name Sarah Neelis

15. Birthplace Belle md

16. Informant Misses Feast (sisters)

Address 605 Bosley Dr

17. (Burial, cremation, or removal (which?)) Burial Date thereof Mar-30-48  
(month) (day) (year)

Cemetery or crematory Green Mount

Location Baltimore md

18. Funeral director Shaw-Morris

Address 108 W 7th Ave.

19. 3/29 48 R. J. Bedard  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1948 at 9:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1947 to March 28 1948 and that I last saw h. or alive on Mar 28 1948

Immediate cause of death Coronary thrombosis DURATION Sudden  
Due to Arteriosclerosis  
Due to Myocardial Insufficiency  
Other conditions Senility  
(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel J. H. Thor. J. J. J. M. D. or other  
Towson md Address Date signed 3/29/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age and birth date shown on:

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02469

MAY 11 APR 6 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 39

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Phoenix  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Phoenix  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Caper Mill Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war —

## 3. (a) FULL NAME

Virginia May Fee

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

George Warren Fee7. Birth date of  
deceased (mo., day, yr.)Nov 13 - 1871 18696. (c) If alive, give age — years

## 8. AGE:

79 Years

## Months

4

## Days

16

## If less than one day

— hrs. — min.

## 9. Birthplace

Baltimore, Md  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

David Newman

## 13. Birthplace

Pa

## 14. Maiden name

Louisa Rudolph

## 15. Birthplace

Paris France

## 16. Informant

Blanche May Wright

## Address

Phoenix, Md

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

March 31 1948  
(month) (day) (year)

## Cemetery or crematory

David Ridge

## Location

Pikesville, Md

## 18. Funeral director

Frank H. Howard

## Address

Pikesville, Maryland

## 19. (Date rec'd by registrar)

3/29 48

## 19. (Date rec'd by registrar)

48Dr. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1948 at 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1946, to March 1948and that I last saw him/her alive on March 26 1948

## Immediate cause of death

Arteriosclerotic heart disease, generalized

## Due to

arteriosclerosis

## Due to

## Other conditions

Hypertension

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please enter the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Elizabeth B. Shewell M.D.  
M. D. or other

## Address

Cookesville, MdDate signed 3/29/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balto.City or town Middle River  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

19 Harrison AveHow long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Fullerton  
(If outside city or town limits, write RURAL and give nearest town)Street No. Fitch Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

EVA FITCH

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married8.(b) Name of husband or wife. Wm F Fitch

8.(c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) 2/27/948. AGE: Years Months Days If less than one day  
54 0 27 hrs. min.9. Birthplace Balto. Co. Md.  
(Town, county, and state)10. Usual occupation. at home

11. Industry or business

12. Name John Miller13. Birthplace Balto. Co. Md.14. Maiden name Eva Shutz15. Birthplace Balto. Co. Md.18. Informant Wm F FitchAddress Fitch Ave, Fullerton17. Burial Date thereof 3 30 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JosephsLocation Balto. Co. Md.18. Funeral director Larsen Funeral HomeAddress 7401 Belair Rd.19. 3/26/48 Wm S. Cronelly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1948 at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1948 to March 26 1948 and that I last saw him alive on March 26 1948Immediate cause of death Pulmonary edema DURATION 1 hrDue to Cardiac decompensation 6 daysDue to Hypertensive cardiovascular disease ?Other conditions Coronary thrombosis 6 days  
Diabetes mellitus; diabetic acidosis ?  
(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm S. Cronelly MD M. D. or otherAddress Ridge Rd, Balt - 6 Date signed March 27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 8 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02471

CERTIFICATE OF DEATH

Reg. Dist. No. 44

FILM No. G 114 MAR 19 1948

1. PLACE OF DEATH:  
County.....Baltimore  
City or town.....Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....4 hours  
Hospital, institution, or street address where death occurred:  
Veterans Administration Hospital  
How long in hospital or institution?.....4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....Maryland.....County.....  
City or town.....Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....819 Park Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....WW

3. (a) FULL NAME  
THOMAS A. FRERE

3. (b) Social Security Number  
Unknown 212-16-4826

4. Sex.....Male  
5. Color or race.....White  
6. (a) Single, married, widowed, or divorced.....Married  
8. (b) Name of husband or wife.....Lucy M. Frere  
7. Birth date of deceased (mo., day, yr.).....January 31, 1897  
8. (c) If alive, give age.....52 years  
8. AGE: Years.....51 Months.....50/ Days.....1 If less than one day.....hrs.....min.....

9. Birthplace.....Tompkinsville, Md.  
(Town, county, and state)  
10. Usual occupation.....Unemployed  
11. Industry or business.....

12. Name.....William J. Frere  
13. Birthplace.....Washington, D.C.  
14. Maiden name.....Josephine Phillips  
15. Birthplace.....Maryland

16. Informant.....Clinical Records, Vets. Adm. Hosp.  
Address.....Fort Howard, Md.

17. Burial.....Date thereof.....3/15/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory.....Baltimore National Cemetery  
Location.....Baltimore, Md.  
Howard M. Blight Jr.  
18. Funeral director.....Howard Blight Funeral Home  
Address.....4914 Belair Road, Baltimore, Md.

19. 3/13 19 48 a.p. Adrich  
(Date rec'd by registrar) a.s. Registrar

MEDICAL CERTIFICATION

30. DATE OF DEATH.....March 12.....19 48.....at 5:10 A.M.

31. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 12.....19 48.....to March 12.....19 48.....

and that I last saw him alive on March 12.....19 48.....

Immediate cause of death.....LACERATION AND EDEMA  
OF BRAIN.....DURATION.....

Due to.....Fractured skull.....2 days.....

Due to.....Cause not known.....

Due to.....Thought to have been caused  
by a fall down a staircase.....

Other conditions.....into a radiator [4/27/48 also].....

(Include pregnancy within 8 months of death)

Major findings of operations.....Date of op.....

Autopsy results.....Substantiated above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:  
Accident, suicide, or homicide.....Probably accident.....Date of.....Probably March 11, 1948

Where did injury occur?.....Not known.....(City or town).....(County).....(State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?.....

23. SIGNATURE.....M.B. Davis M.D.  
Address.....Superior Medical Exam. Bureau  
Date signed.....3/12/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02472

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 9 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8 Terrace Road  
(If rural, give LOCATION)2.(a) if veteran, name war WWI

## 3. (a) FULL NAME

FRANK J. GEGOREK

## 3. (b) Social Security Number

Unknown

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Josephine Gegorek6.(c) If alive, give age 50 years

## 7. Birth date of

deceased (mo., day, yr.) Oct. 10, 1897

## 8. AGE:

Years

Months

Days

If less than one day

50521

.....hrs. ....min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Salesman

## 11. Industry or business

## FATHER

12. Name Frank Gegorek13. Birthplace Prussia

## MOTHER

14. Maiden name Frances KUMASA15. Birthplace Baltimore, Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 4-3-48  
(month) (day) (year)Cemetery or crematory Baltimore National Cemetery  
Baltimore, Md.

Location

18. Funeral director Hiakowski Funeral Home

Address

2007 Eastern Ave., Balto., Md.19. April 2, 1948  
(Date filed by registrar)Sw. Hedrich  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1948, at 8:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 22, 1948, to March 31, 1948  
and that I last saw him alive on March 31, 1948

## Immediate cause of death

Thrombosis of left anterior desc.  
Coronary Artery with infarction

## DURATION

2 wks  
plus

Due to

Due to

Other conditions Occlusion of right coronary  
artery

(Include pregnancy within 8 months of death)

unknown

## Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

## 23. SIGNATURE

H.C. ManaughH.C. MANAUGH, M. D. Chief Professional  
Address VAH, Ft. Howard, Md. Ser. Date signed 4-1-48

W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

02473

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Towson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... LifeHospital, institution, or street address where death occurred:  
35 Willow Avenue

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 35 Willow Avenue  
(If rural, give LOCATION)2. (a) If veteran, name war... None

## 3. (a) FULL NAME

FLORENCE MAY GERMAN

## 3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	--

6. (b) Name of husband or wife... William Morris German7. Birth date of deceased (mo., day, yr.) September 5, 1887  
6. (c) If alive, give age... years

8. AGE: Years <u>60</u>	Months <u>5</u>	Days <u>29</u>	If less than one day hrs. min.
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9. Birthplace... Towson, Baltimore Co., Maryland  
(Town, county, and state)10. Usual occupation... Housewife11. Industry or business... At Home12. Name... John T. Ritter13. Birthplace... Maryland14. Maiden name... Sarah E. Biddison15. Birthplace... Maryland16. Informant... William Morris GermanAddress... 35 Willow Ave., Towson, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof... Mar. 6, 1948  
(month) (day) (year)Cemetery or crematory... Prospect Hill CemeteryLocation... Towson, Balto. Co., Maryland18. Funeral director... John Burns, SonsAddress... Towson, Maryland19. March 6, 48 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 4, 1948 at 3:10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 48 to 4 mch. 48and that I last saw him alive on 4 mch. 1948Immediate cause of death... Arteriosclerosis  
Cardio-Vascular DiseaseDURATION... 24Due to... DiabetesDue to... 10 yrsOther conditions... Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations... NoneDate of op... NoneAutopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Charles E. Keir M.D.Address... 6701 York Rd. Balt. Md. 4 mch. 48Date signed... 4 mch. 48

RECEIVED

MAR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Harbold

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02474

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County..... Parkville  
City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8401 Harford Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Parkville.....

City or town..... Baltimore.....  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 8401 Harford Road.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

William A. Gilley

## 3. (b) Social Security Number

267-05-9037

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife.....

Margaret Ann

7. Birth date of deceased (mo., day, yr.)

June 6th, 1865

6.(c) If alive, give age..... years

8. AGE:

Years

82

Months

9

Days

23

If less than one day

hrs.

min.

9. Birthplace.....

Baltimore, Md.

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

FATHER  
MOTHER

12. Name.....

James T. Gilley

13. Birthplace

Baltimore

14. Maiden name.....

Mary Rilley

15. Birthplace

Baltimore

16. Informant.....

Mrs. Margaret A. Gilley

Address

8401 Harford Road

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

4-1-48

(month) (day) (year)

Cemetery or crematory.....

Loudon Park

Location.....

Baltimore

Leonard J. Ruck

18. Funeral director.....

Address

5305 Harford Road, #14

19.

3/31  
(Date rec'd by registrar)

19.

A.W. Hedrick  
DM Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 28th, 1948, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1942, to March 28, 1948, and that I last saw him alive on March 28, 1948.

Immediate cause of death.....

Carcinoma of Caecum  
Chronic myocarditis

DURATION

5 years

Due to.....

Due to.....

Other conditions.....

Hepatitis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

H.V. Harbold M.D.

M. D. or other

Address..... 4706 Harford Road..... Date signed 3/29/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

934

02475

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 48 years, 7 months, 27 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 48 years, 7 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town ?  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ?  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war. \_\_\_\_\_

## 3. (a) FULL NAME

Jacob Gross

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

1863

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

85

?

?

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

Unknown

## MOTHER FATHER

## 12. Name

?

## 13. Birthplace

?

## 14. Maiden name

?

## 15. Birthplace

?

## 16. Informant

Hospital records

## Address

Catonsville-28, Maryland

## 17.

Buried

Date thereof

3-29-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Spring Grove State Hospital

## Location

Catonsville 28, Md.

## 18. Funeral director

Spring Grove State Hospital

## Address

Catonsville 28, Md.

## 19.

3-29

19

48

V.E. Hargis

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 19 1948 at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_

19

Immediate cause of death

DURATION

Acute Cardiac Failure

Due to

Coronary vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. P. R. Kieffer

M. D. or other

Address

1010 Linden

Date signed

3-19-48

PLEASE WRITE PLAIN INK. Supply every item of information. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

02476

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Catonsville Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Unknown  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 906 Frederick Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Henry Gunther

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Unknown Mary Gunther  
 7. Birth date of deceased (mo., day, yr.) December 31 1861  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 86 Months 2 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Unknown Baltimore County  
 (Town, county, and state)  
 10. Usual occupation Florist & Gardner  
 11. Industry or business Self

12. Name Hermann Gunther  
 13. Birthplace Germany  
 14. Maiden name A nna, K.  
 15. Birthplace Germany

16. Informant Hospital records  
 Address Catonsville, 28, Maryland  
 17. Burial Burial Date thereof March 16, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Loudon Park  
 Location Baltimore

18. Funeral director Frederick T. Cole  
 Address 1300 W. Lombard St.  
 19. 3/15 48 A.W. Friedrich  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 48 at 5:40 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 19 48 to March 13 19 48  
 and that I last saw h. im alive on March 13 1948

Immediate cause of death Left lower lobar pneumonia  
undiagnosed  
 Due to Generalized arteriosclerosis Indef  
Arteriosclerotic heart disease "  
 Due to Hypertensive cardio-vascular "

Other conditions Decubitus  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M. D. M. D. or other  
Catonsville, 28, Md. Date signed 3/13/48

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30- 02477

## 1. PLACE OF DEATH:

County Baltimore  
 City or town White House  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Entire Life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore  
 City or town White House  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George Edward Hale

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Edella J Hale

## 6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Sept 7 - 1882

## 8. AGE:

Years 65 Months 6Days 19

If less than one day

hrs.

min.

## 9. Birthplace

White House B Co Md  
(Town, county, and state)

## 10. Usual occupation

Read Lectures

## 11. Industry or business

Read Bldg + Repair

## 12. Name

Johnny R Hale

## 13. Birthplace

Md

## 14. Maiden name

Laura Alban

## 15. Birthplace

Md

## 16. Informant

Mrs Edella Hale

Address

Wifredo Md

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 29, 1948  
(month) (day) (year)

Cemetery or crematory

Foreston Cemetery

Location

Parkton Md RD

## 18. Funeral director

Address

Jacob HartensteinNew Freedom Pa

## 19. (Date rec'd by registrar)

Mar 27 1948Cherish L. B. B.RegisfreeRegisfree

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 26 1948 at 1:15 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 - 1947 to March 26 1948and that I last saw him alive on Feb 21 1948

## Immediate cause of death

Coronary Thrombosis Sudden

## Due to

Chronic Myocarditis Sept 1-48

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

J. E. Bush Md

M. D. or other

Address

Hampstead Md

Date signed

3-26-48

RECEIVED

APR 3 1948

BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

02478

## 1. PLACE OF DEATH

County Baltimore Registration Dist. No. 30  
 Village or City Catonsville No. 134 St.        Ward         
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S. If of foreign birth?        yrs.        mos.        ds.

## 2. FULL NAME

Julia A. Hallouell If U. S. Veteran, specify WAR         
 (a) Residence: No. Brookville Md. St.        Ward.         
 (Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>      </u>		
6. DATE OF BIRTH (month, day, and year) <u>March 29-1863</u>		
7. AGE Years <u>84</u>	Months <u>11</u>	Days <u>10</u>
If LESS than 1 day, <u>      </u> hrs. or <u>      </u> min.		
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Home maker</u>		11. Total time (years) spent in this occupation <u>      </u>
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>      </u>		
10. Data deceased last worked at this occupation (month and year) <u>      </u>		

12. BIRTHPLACE (city or town) Sandy Spring Md.  
 (State or country)       

13. NAME James Hallouell  
 14. BIRTHPLACE (city or town) Pa.  
 (State or country)       

15. MAIDEN NAME Margaret Stöcker  
 16. BIRTHPLACE (city or town) Sandy Spring Md.  
 (State or country)       

17. INFORMANT Mrs. Florence Carpenter  
 (Address) 3715 Hamilton St. Phila. Pa.

18. BURIAL, CREMATION, OR REMOVAL  
 Place Sandy Spring Md. Date March 13, 1948

19. UNDERTAKER Wm. Reuben Pumphrey  
 (Address) Bethesda Md.

20. FILED March 11, 1948 V. E. Harvey  
 Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH March 10, 1948  
 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from August 5, 1947, to March 10, 1948.  
 I last saw him alive on March 10, 1948; death is said to have occurred on the date stated above, at 7:30 p. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Myocardial Decompensation  
Generalized Atherosclerosis  
 Date of onset 10/1/47  
about 1935

Other Contributory Causes of Importance:  
decelity due to atherosclerosis 1943

Name of operation        Date of         
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:  
 Accident, suicide, or homicide?        Date of Injury       , 19         
 Where did Injury occur?         
 (Specify city or town, county and State)  
 Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury         
 Nature of Injury       

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify         
 (Signed) William R. Gallagher M. D.  
 (Address) 6209 Frederick Rd. Balt. 28

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as “employee,” “worker,” “operative,” etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as “store,” “factory,” “mill,” etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term “laborer” when a more precise statement of the occupation can be secured. Do not use the word “mechanic,” but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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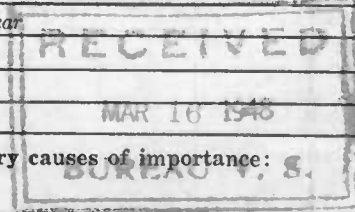
Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02479

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Sparrow Point  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

1259 Beechwood Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Sparrow Point  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1259 Beechwood Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Betty Ruth Hanlin

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) October 27, 1947

## 8. AGE:

Years

Months

Days

If less than one day

—422

hrs.

min.

## 9. Birthplace

Baltimore County, Maryland  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

none

## FATHER

## 12. Name

Walter M. Hanlin

## 13. Birthplace

Wheeling W. Va.

## MOTHER

## 14. Maiden name

Betty Ruth Bell

## 15. Birthplace

Wheeling W. Va.

## 16. Informant

Walter M. Hanlin

## Address

1259 Beechwood Rd., Sparrow Point

## 17. Burial

Burial

## Date thereof

March 23, 1948  
(month) (day) (year)

(Burial, cremation, or removal, Which?)

## Cemetery or crematory

Oak Lawn Cemetery

## Location

Eastern Ave.

## 18. Funeral director

Roland L. Fisher

## Address

2112 Dundalk Ave.

## 19. Mar. 23

19 48Dawson L. Parkey  
Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 48 at 7 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 27 19 47 to March 22 19 48  
and that I last saw her alive on March 19 19 48

## Immediate cause of death

Candid - respiratory failure

## DURATION

Due to Pneumonia - broncho  
[4/2/48 also]1 weekDue to Mongolismlife

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

## 23. SIGNATURE

Robert E. Farber, M.D.  
M. D. or otherAddress Sparrow Point, Md. Date signed 3/22/48

**RECEIVED**

**MAR 26 1948**

**BUREAU V. S.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 44

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland  
(b) Street address: Sparrows Point Street  
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 3 (a) FULL NAME

Woodrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

M

5. Color or race

C

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1917

8. AGE:

Years

Months

Days

If less than one day

31

hr.

min.

9. Birthplace

Georgia

(Town, county, and state)

10. Usual Occupation

Chauffeur

11. Industry or business

FATHER

12. Name

William Hardrick

13. Birthplace

Ga.

MOTHER

14. Maiden Name

Mary Butler

15. Birthplace

Ga.

16 (a) Informant

William Hardrick

(b) Address

206 N. Ann St

17 (a)

Burial  
(Burial, cremation, or removal)

(b) Date thereof

made 29/48  
(month) (day) (year)

(c) Cemetery or crematory

Mt Calvary Cem.

Location

A.A. County, Md

18 (a) Funeral director

Mrs. R. H. Elliott &amp; Son

(b) Address

1129 N. Carroll St

19 (a)

3/29/48  
(Date rec'd by registrar)A.W. Hedrick  
Registrar

## 2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No.

206 N. Ann Street

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH

3-26-48

at

A.M.

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☐, suicide ☐,homicide ☒, undetermined ☐ and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

Bullet wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury

3/26/48

A.M.

(b) Where did injury occur?

1002 "J" Street

(c) Did injury occur at home, on farm, industrial place, in public

place?

While at work?

No

(d) Means of injury

23. Signature

E. L. Ryan M.D.

Date signed

3/26/48

Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County.....Mount Wilson, Balto. Co., Md.  
 City or town.....Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs., 7 mos., 17 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson  
Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 3 yrs., 7 mos., 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....  
 City or town.....Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3640 Malden Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mrs. Alice Harvey

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

Edward C. Harvey

## 6. (c) If alive, give age.....years

## 7. Birth date of

deceased (mo., day, yr.)

November 21, 1891

## 8. AGE:

Years

Months

Days

If less than one day

56

3

22

hrs.

min.

## 9. Birthplace

Howard Co., Maryland

(Town, county, and state)

## 10. Usual occupation

Housework

## 11. Industry or business

FATHER

## 12. Name

Edward Steele

## 13. Birthplace

Washington, D. C.

MOTHER

## 14. Maiden name

Bella Grimes

## 15. Birthplace

Howard Co., Maryland

## 16. Informant

Mrs. Alice Harvey

## Address

3640 Malden Ave., Balto., Md.

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 17, 1948

(month) (day) (year)

## Cemetery or crematory

St. Mary's Cemetery

## Location

Hampden, Maryland (Balto.)

## 18. Funeral director

Chenoweth Funeral Home

## Address

3615 Chestnut Ave., Balto., Md.

## 19.

Mar. 14, 1948

(Date rec'd by registrar)

Earl T. Webster

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 14,.....1948.....11:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26,.....1944.....to Mar. 14,.....1948and that I last saw her alive on March 14,.....1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

8 yrs.Due to Tubercle Bacilli

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations.....No operation

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Stewart S. Shaffer M.D.

M. D. or other

Address

Mt. Wilson, Md.

Date signed

3/14/48

Rec'd 3-18-48 Dr. E. E. Nichols

RECEIVED

MAR 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02482

Reg. Dist. No. 30

1. PLACE OF DEATH: 148 - Winters Ave.  
County: Baltimore  
City or town: Catonsville Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Henderson

(b) Social Security Number

4. Sex: M. 5. Color or race: Col 6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1879  
6. (c) If alive, give age: — years

8. AGE: 68 Years Months Days If less than one day  
md. hrs. min.

9. Birthplace: md. (Town, county, and state)  
Garden.

10. Usual occupation

11. Industry or business

12. Name: Hezekiah Henderson

13. Birthplace: md. ?

14. Maiden name: Miranda ?

15. Birthplace: md.

16. Informant: Mr Henderson Jr.

Address: #7 - Melrose Ave

Burial

Date thereof: 3-30-48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory: O'Eller Md.

Location: A. Halstead

18. Funeral director: A. Halstead

Address: 918 - Druid Hill Ave

3/29 1948 R.W. Hedrick

(Date rec'd by Registrar)

19. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State: md. County: Catonsville

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 147 - Winters Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26<sup>th</sup> 1948 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-8-48 to 3-26-48

and that I last saw him alive on 3-26-48

Immediate cause of death

Coronary Occlusion 15 min.

Due to: Mitral Insufficiency ?

Due to: Atherosclerotic Heart Disease ?

Other conditions: Left Inguinal Hernia

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. J. Maloney

Address: 57 Winters Ave

Catonsville Md

Date signed: 3/26/48

M. D. or other

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

02483

38

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County BALTIMORE

City or town TOWSON  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORE

City or town TOWSON  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 302 LINDEN AVE  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3. (a) FULL NAME

MARY A. HENRY

### 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED

6.(b) Name of husband or wife JAMES A.

7. Birth date of deceased (mo., day, yr.) AUG. 5, 1880  
6.(c) If alive, give age ..... years

8. AGE: Years Months Days It less than one day  
67 7 11 ..... hrs. .... min.

9. Birthplace BALTIMORE, MARYLAND  
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business OWN HOME

12. Name JOHN J. RODDY

13. Birthplace IRELAND

14. Maiden name MARIAH NORTON

15. Birthplace IRELAND

16. Informant MRS. EDWARD A. JELKS

Address 302 LINDEN AVE. TOWSON

17. BURIAL Date thereof 3/19/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory NEW CATHEDRAL

Location BALTIMORE, MARYLAND

18. Funeral director WILLIAM COOK, INC.

Address 1217 ST. PAUL ST.

19. 3/12 19 48 A.W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 19 48 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 13 19 48 to March 16 19 48  
and that I last saw him/her alive on March 16 19 48

Immediate cause of death Coronary thrombosis DURATION 4 days

Due to Arteriosclerotic Hypertensive 10 yrs.

Due to Cardiovascular disease 8 yrs.

Due to Diabetes Mellitus 10 yrs.

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Anthony F. Calogera M.D. or other

Address 5217 York Rd Date signed 3/16/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02484

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore CountyCity or town Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5639 Oregon Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5639 Oregon Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Andrew Herman

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Alwina W. Herman

B. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

Aug. 17, 1879

## 8. AGE:

68

Years

Months

6

Days

23

If less than one day

\_\_\_\_\_ hrs.

\_\_\_\_\_ min.

## 9. Birthplace

Germany

(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

MOTHER FATHER

## 12. Name

Herman

## 13. Birthplace

Germany

## 14. Maiden name

Unknown

## 15. Birthplace

Germany

## 16. Informant

Mrs. Alwina W. Herman

## Address

5639 Oregon Ave.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 13/48.  
(month) (day) (year)

## Cemetery or crematory

Loudon Park

## Location

3801 Frederick Ave.

## 18. Funeral director

Larry H. Witke

## Address

4101 Edmondson Ave.

## 19.

(Date rec'd by registrar)

March 18A. W. Gelmer

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 10/48.

19

at

3

M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1 1948 to 3/10 1948  
and that I last saw h. unstable on 3/10 1948

## Immediate cause of death

Carcinoma of  
oesophagus

## DURATION

6 months

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Carcinomaof esophagus Date of op. 8/6/47

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Benjamin Miller

M. D. or other

## Address

2030 W. StevensDate signed 3/11/48

MARGIN RESERVED FOR BINDING

VS A16 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

02485

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodstock  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Woodstock  
(If outside city or town limits, write RURAL and give nearest town)Street No. Davis Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah E Higgs

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FWWidow6.(b) Name of husband or wife William T Higgs

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 18838. AGE: Years Months Days If less than one day  
65 1 11 hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name William Howard13. Birthplace Va14. Maiden name Sarah E. Cook15. Birthplace Va16. Informant Lillian JonesAddress Randallstown, Md17. Burial Date thereof 4-5-48  
(Burial, cremation, or removal. Which?) (Month) (Day) (Year)Cemetery or crematory Good ShepherdLocation Ellicott City, Md18. Funeral director F. C. HiginbothamAddress Ellicott City, Md.19. 4/3/48 19 48  
(Date rec'd by registrar) (Month) (Day) (Year) Registrar W. W. Higinbotham

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 48 10:40 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 42 to Mar 31 19 48and that I last saw him alive on March 31 19 48  
Immediate cause of death Coronary Thrombosis

DURATION

15 minutesDue to Cerebral Hemorrhage on two occasions in past year.  
Due to ArteriosclerosisOther conditions Arteriosclerosis 6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. A. Lally M.D.Address 3517 Edmondson Date signed April 2 1948

Dr Kelly  
3517 Edmonson Ave

Rec'd V.S.  
4/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02486

Reg. Diat. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)Now long in above place of death? 0 yrs., 3 mos., 19 daysHospital, institution, or street address where death occurred: Mt. WilsonBranch, Md. Tuberculosis SanatoriumHow long in hospital or institution? 0 yrs., 3 mos., 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2942 Clifton Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Sarah R. Hiss

## 3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Widow</u>

6. (b) Name of husband or wife Benjamin E. Hiss7. Birth date of deceased (mo., day, yr.) September 12, 1896

8. AGE:	Years	Months	Days	It less than one day
	<u>51</u>	<u>5</u>	<u>24</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Henry Warner13. Birthplace Hagerstown, Maryland14. Maiden name Sadie Ryan15. Birthplace Baltimore, Maryland16. Informant Carlyn E. Riggin, DaughterAddress 2942 Clifton Ave., Balto., Md.17. Burial Date thereof Mar. 10, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olivet CemeteryLocation 2930 Frederick Ave., Balto., Md.18. Funeral director G. Howard Strong Funeral HomeAddress 3207 W. North Ave., Balto., Md.19. Mar. 7, 1948 Earl T. Webster  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1948 5:05 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 17, 1947 to March 7, 1948 and that I last saw him/her alive on March 7, 1948Immediate cause of death Pulmonary Tuberculosis DURATION 7 mos.Due to Tubercle Bacilli

Due to

Other conditions Diabetes Mellitus Unknown

(Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op.Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or otherAddress Mt. Wilson, Md. Date signed 3/7/48Rec'd - 3-10-48 Dr. E. E. Nichols

RECEIVED

MAR 11 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mt. Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Henry Scott Hite

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Elizabeth Gertrude Hite7. Birth date of deceased (mo., day, yr.) April 8 - 1873 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 74 Months 11 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Elkton, Virginia  
(Town, county, and state)10. Usual occupation Gardener

11. Industry or business

12. Name Unknown13. Birthplace Virginia14. Maiden name Unknown15. Birthplace Virginia16. Informant Albert E. Hite, Jr.Address 1203 Lake Avenue17. Burial Date thereof March 13, 1948  
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Moreland Memorial ParkLocation Baltimore Co. Maryland18. Funeral director Burgee Funeral HomeAddress 3631 Falls Road19. 3/10 19. 48 N-W Hedrick  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Mt. Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1203 Lake Avenue  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 - 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1948 to March 9 1948  
 and that I last saw him alive on March 8 1948

Immediate cause of death Cardiac Decompensation

DURATION

Due to Arteriosclerosis CVD 3 wks

Due to \_\_\_\_\_ ?

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Louise J. Hmanek M.D.Address 3711 Fall Rd Date signed 3-9-48

MARGIN RESERVED FOR BINDING

VS. A15

9-45-12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 17 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02489

Reg. Dist. No. 43

### 1. PLACE OF DEATH:

County Balto

City or town Raspeburg Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
4408 Glenmore Ave

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Raspeburg  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4408 Glenmore Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

Edward G. Hoover

### 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary S. Hoover

7. Birth date of deceased (mo., day, yr.)

Dec 31st 1871

6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day

76

2

13

hrs. min.

9. Birthplace

Hagerstown Md.  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Painter

12. Name

John N. Hoover

13. Birthplace

Hagerstown Md.

14. Maiden name

Amanda Michael

15. Birthplace

Hagerstown Md.

16. Informant

Mary S. Hoover

Address

4408 Glenmore Ave

17. (Burial, cremation, or removal, Which?) Date thereof

Burial

3/17/48  
(month) (day) (year)

Cemetery or crematory

Balto

Location

" Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19. (Date rec'd by registrar)

3/18

48

D. W. Hedrick  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 14th 1948 at 2:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1942 to March 14 1948 and that I last saw him alive on March 14 1948

Immediate cause of death MYOCARDIAL DEGENERATION DURATION 6 yrs +

Due to CORONARY ARTERIOSCLEROSIS " " ARTERIAL HYPERTENSION "

Due to

Other conditions SENILITY " GENERAL ARTERIO-SCLEROSIS " (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Whaden Md. M. D. or other

Address 6331 Belair Rd - G Date signed 3/18/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02490

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Eatonville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 2 months, 4 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 year, 2 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3905 Ridgewood Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Emma Householder

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Daniel W. Householder  
dead 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) January 26, 1872

8. AGE: Years 76 Months 1 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Easton, Maryland  
 (Town, county, and state)

10. Usual occupation housewife  
home

11. Industry or business \_\_\_\_\_  
 12. Name Benjamin F. Harrison  
 13. Birthplace Maryland

14. Maiden name Martha Jan. Hunt  
 15. Birthplace Maryland

16. Informant Mrs. Laura M. Gaither  
 Address 3905 Ridgewood Ave

17. Burial Date thereof 3/4/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Lorraine  
 Location Alto. Co., Md.

18. Funeral director WM. J. TICKNER & SONS INC  
 Address BALTIMORE, MD.

19. 3/3 48 A.W. Hedrick  
 (Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 48 3 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Cerebral thrombosis

Due to Cardiovascular disease

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. S. M. Kieffer Kept filed  
 M. D. or other \_\_\_\_\_

Address 1010 Leeds an Date signed Mar 1, 48

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

02491

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1819 Winans Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1819 Winans Avenue  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Marie Bertha Hunt

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>female</u>	<u>white</u>	<u>widowed</u>

6. (b) Name of husband or wife John J. Hunt  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 27, 1882

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>7</u>	<u>27</u>	hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Frederick Krodel13. Birthplace Berlin, Germany14. Maiden name Elizabeth Unknown15. Birthplace Berlin, Germany16. Informant Oscar L. HuntAddress 1919 Winans Avenue, Halethorpe17. burial Date thereof 3/29/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park CemeteryLocation Baltimore, Maryland18. Funeral director Wm. Cook, Inc.Address 1217 St. Paul Street19. March 27, 1948 A. W. Hedrick  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24, 19 48 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 19 48 to March 24 19 48 and that I last saw him alive on 3-24-48

Immediate cause of death

Chronic MyocarditisDue to Cystic Thyroid

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. S. Larson M.D.Address 1711 Selma Ave. Date signed 3/25/48

Evidence for change of birth date is shown

on Film G115 4/21/48 js

Letter From Dr. Bennett Stoen

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124a

02492

38

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Juttsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Juttsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Monroe Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Thirskfield Jackson

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widower

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30 1948 at 2:32 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1948 to Mar 30 1948 and that I last saw him alive on March 30 1948

Immediate cause of death

Heart failure

DURATION

7 DaysDue to Chronic hepatic cirrhosisDue to Chronic alcoholism

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bennett A. Stoen

M. D. or other

Address Lutherville Date signed 3/31/48

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) MAY 6, 1888

6.(c) If alive, give age years

8. AGE: 78 Years 17 Months 1869 Days

If less than one day

9. Birthplace Ellicott City, MD  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Marie L. Ayers - R. N.Address Seminary Ave.17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 4/1/48

(month) (day) (year)

Cemetery or crematorium Oleasant RestLocation Lowsa, Md.18. Funeral director Mrs. George W. HollandAddress 1631 Quind Hill Ave.4/1 1948 Registrar

(Date rec'd by registrar)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore

City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bond Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

### 3. (a) FULL NAME

Josephine Tucker Johnson

### 3. (b) Social Security Number

4. Sex F.

5. Color or race C

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife John Johnson

7. Birth date of deceased (mo., day, yr.) March 19, 1876

6.(c) If alive, give age .....

8. AGE: Years 72 Months .....

9. Birthplace Maryland  
(Town, county and state)

10. Usual occupation Housewife

11. Industry or business .....

12. Name Eli Tucker

13. Birthplace Md

14. Maiden name Mary Thomas

15. Birthplace Md

16. Informant Mr. John Johnson

Address 20 Bond Ave

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 3-27-48  
(month) (day) (year)

Cemetery or crematory St. Lukes Cem

Location Reisterstown Md

18. Funeral director Mrs. Frances H. Hensley

Address 578 W. Biddle St.

19. 3/27 19 48 D.W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 48 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-28-41 19 .....

and that I last saw him alive on 3-23 19 48

Immediate cause of death .....

Chronic nephritis  
Decompensated hypertension  
— E.V. disease

### DURATION

3 yrs  
7 yrs

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

NONE Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? NONE  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury .....

Injured at work?

23. SIGNATURE D.D. Caples, M.D.

M. D. or other

Address Reisterstown, Md. Date signed 3-24-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02495

## CERTIFICATE OF DEATH

Reg. Dist. No. *44*

### 1. PLACE OF DEATH

County *Balt.*  
City or town *Sparks Point*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *12 years*  
Hospital, institution, or street address where death occurred:  
*Pipe mill*

How long in hospital or institution?

### 3. (a) FULL NAME

*Reley Johnson*

### 3. (b) Social Security Number

### 4. Sex

*Male*

### 5. Color or race

*Col*

### 6. (a) Single, married, widowed, or divorced

*Married*

### 6. (b) Name of husband or wife

*Gertrude Johnson*

### 7. Birth date of deceased (mo., day, yr.)

*April 4, 1913*

### 6. (c) If alive, give age..... years

### 8. AGE:

Years *34* Months *11* Days *14* If less than one day  
hrs. min.

### 9. Birthplace

*South Carolina*  
(Town, county, and state)

### 10. Usual occupation

*Laborer*

### 11. Industry or business

FATHER  
MOTHER

### 12. Name

*Henry Johnson*

### 13. Birthplace

*South Carolina*

### 14. Maiden name

*Ella Wiley*

### 15. Birthplace

*South Carolina*

### 16. Informant

*Gertrude Johnson*

### Address

*1849 N. Spring St.*

### 17.

*Shipped* Date thereof *March 21, 1948*  
(Burial, cremation, or removal) (month) (day) (year)

### Cemetery or crematory

*York County, South Carolina*

### Location

*York County, South Carolina*

### 18. Funeral director

*Rayner Sanders*

### Address

*1412 E. Preston Street*

### 19.

*3/19/48* *A.W. Pedrick*  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

### State

*md* County *---*

### City or town

*Baltimore*  
(If outside city or town limits, write RURAL and give nearest town)

### Street No.

*1849 N. Spring Ct.*  
(If rural, give LOCATION)

### 2. (a) If veteran, name war

*---*

## MEDICAL CERTIFICATION

### 20. DATE OF DEATH

*Mar. 18, 1948* at *6 A.M.*

### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....  
and that I last saw him..... alive on..... 19.....

### Immediate cause of death

*Ruptured aorta*

### Due to

*Aortic aneurysm*  
*due to syphilis*  
(4/23/48 U.S.)

### Other conditions

(Include pregnancy within 3 months of death)

### Major findings of operations

Date of op. ....

### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

### Where did injury occur?

(City or town) (County) (State)

### Injured at home, farm, industry, public place (where?)

### Means of injury

### Injured at work?

### 23. SIGNATURE

*Depue Medical*  
Address *Baltimore, Md* Date signed *3/18/48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reg. Dist. No.

(I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02497

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County CatonsvilleCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3 St. Timothy Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County New YorkCity or town Staten Island  
(If outside city or town limits, write RURAL and give nearest town)Street No. 141 Pelton Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sophia M. Johnson

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife George7. Birth date of deceased (mo., day, yr.) April 10-18588. AGE: Years 89 Months 11 Days 8 If less than one day

hrs. min.

9. Birthplace Moss Norway  
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name Kristian Ellefson13. Birthplace Norway14. Maiden name Karen Svendsen15. Birthplace Norway16. Informant Mrs. Henry JohnsonAddress 3 St. Timothy Lane17. Burial Valhalla Date thereof 3/12/48  
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory

Location Staten Island N.Y.19. Funeral director Leonard J. CookAddress 530 S. Maryland Road19. 3-19-48 Registrar [Signature]  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18th 1948 at 11 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1st 1948  
and that I last saw him alive on March 18 1948

Immediate cause of death

Myocarditis  
Myocarditis

Due to

arteriosclerosis

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. B. [Signature] M. D. or other  
Address 30 E. Madison St. Date signed 3/19/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 79 yrs

Hospital, institution, or street address where death occurred:

10 Newburg Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 10 Newburg Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Frederence Jones

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

6. (c) If alive, give age ..... years

7. Birth date of

deceased (mo., day, yr.)

Dec. 27, 1868

8. AGE:

Years

Months

Days

If less than one day

79221

hrs.

min.

9. Birthplace

Catonsville Balto. Co. Md.

(Retired)

10. Usual occupation

Government Employee

11. Industry or business

Post Office Dept.

12. Name

Reuben Jones

13. Birthplace

Catonsville, Md.

14. Maiden name

Julia W. Thomas

15. Birthplace

Baltimore, Md.

16. Informant

Miss Julia W. Jones

Address

10 Newburg Ave. Catonsville

17. Burial

Burial

(Burial, cremation, or removal. Which?)

Date hereof Mar 23, 1948  
(month) (day) (year)

Cemetery or crematory

Landon Park Cem.

Location

Frederick Ave. Balto. Md.

16. Funeral director

E. Astor Sons

Address

608 Frederick Ave. Catonsville19. 3-2219. 4819. V E. Harris

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19, 1948 at 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 17, 1948 to Mar 19, 1948and that I last saw him alive on Mar 19, 1948

Immediate cause of death

Chronic Cardiovascular disease

DURATION

3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ernest A. Kahan, M.D.Address 1732 Poplar St. R. 1Date signed 3/20/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02499

Reg. Dist. No. 30

1. PLACE OF DEATH: Leewood Ave.  
County Calverton Md.  
City or town Calverton Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Elizabeth Jones.

3. (b) Social Security Number

4. Sex Feem. 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William

7. Birth date of deceased (mo., day, yr.) 2-26-1883 5. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 65 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Calvert Co Md.  
(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Henry Hammond12. Name Md.13. Birthplace Mary J. Perkins14. Maiden name Md.15. Birthplace William J. Jones16. Informant 101- Leewood Ave.Address Rural

17. Burial Date thereof 3-11-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Western StarLocation E. Halstead18. Funeral director 918- Howard Hill Ave.Address 3-9-4819. Dr. H. E. D. H. E. D.

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CalvertonCity or town BaltimoreStreet No. 101- Leewood Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 48 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-5-48 19 48 to 2-7-48 19 48and that I last saw her alive on 2-7-48 19 48

Immediate cause of death

DURATION

Acute Myocarditis 3 daysDue to Broncho-Pneumonia

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. F. Maloney MD

M. D. or other

Address Calverton Md. Date signed 3/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02500

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BALTIMORECity or town TOWSON  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years, 2 months, 1 day

Hospital, institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITALHow long in hospital or institution? 3 years, 2 months, 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. CountyCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2236 Decatur Place, Apt. #304  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

MRS. LUCY TURNER JOY

## 3.(b) Social Security Number

NONE

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widow6.(b) Name of husband or wife Duncan Joy

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep. 19, 1871

## 8. AGE:

Years

Months

Days

If less than one day

766no

hrs.

min.

9. Birthplace St. Louis, Missouri  
(Town, county, and state)10. Usual occupation none

## 11. Industry or business

12. Name Charles Hunt Turner Joy13. Birthplace Missouri14. Maiden name Margaret Barlow15. Birthplace Missouri16. Informant REAR ADMIRAL CHARLES T. JOYAddress U.S. NAVAL PROVING GROUNDS, DALLAM, VA17. BURIAL Date thereof 3/20/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CALVARYLocation ST. LOUIS, MO.18. Funeral director Wm J. Tickner & Sons IncAddress BALTIMORE, MD.19. 3-20-48 A. W. Hedrich  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 1948 at 11:05 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1946 to March 19 1948and that I last saw her alive on March 19 1948Immediate cause of death Bronchopneumonia DURATION 10 daysDue to Senility

Due to

Other conditions Senile psychosis 4 1/2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry M. Murdock M. D. or otherAddress TOWSON, MARYLAND Date signed 3/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *932* *100* *4X*

1. PLACE OF DEATH: *Baltimore*  
 County.....  
 City or town *N. Sparrows Point - "Lodge Forest"*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
*home*  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *md.* County.....  
 City or town *Baltimore City*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *701 St. Paul Street*  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Harry C. Kalben*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife *None*

7. Birth date of deceased (mo., day, yr.) *Apr. 15-1882* 6. (c) If alive, give age..... years

8. AGE: Years *65* Months *10* Days *29* If less than one day  
 hrs. min.

9. Birthplace *Baltimore, md.*  
 (Town, county, and state)

10. Usual occupation *Lawyer*

11. Industry or business *Law*

12. Name *Wm Kalben*

13. Birthplace *Germany*

14. Maiden name *Brother Augusta Yoe*

15. Birthplace *Balt. md.*

16. Informant *Miss Dorothy Kalben (sister)*

Address *701 St. Paul St.*

17. *Burial* Date thereof *3-16-1948*  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory *Baltimore*

Location *Baltimore, md.*

18. Funeral director *STEWART & MOWEN COMPANY*

Address *(C. F. WARDEN BROS.) 100 W. NORTH AVENUE*

19. *3/15* *48* *How. Hedrick*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 14* 19 *48* at .....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 14* 19 *48* to *March 14* 19 *48*  
 and that I last saw him alive on *March 14* 19 *48*

Immediate cause of death..... DURATION

*acute heart failure (sudden)* *6 hours*

Due to *Arterio-sclerotic heart*

Due to *disease*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *W. J. ...* M. D. or other

Address *520 N. Sparrows Pt.* Date signed *3/14/48*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02502

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Sparrows Pt. - 19th  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 642 Oldham Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Albi KANGAS (ALBI KANGAS)

## 3. (b) Social Security Number

213-07-36534. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorcedWidower6. (b) Name of husband or wife Aliina Kangas

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 18838. AGE: Years 61 Months 6 Days 27 If less than one day  
..... hrs. .... min.9. Birthplace Finland  
(Town, county, and state)10. Usual occupation Steel Mill11. Industry or business Lehigh Steel Co. Sp. Pt. Md.12. Name Eljas Kangas13. Birthplace Finland14. Maiden name Tilda ?15. Birthplace Finland16. Informant Mrs. Fanny Karhu-daughterAddress 16833 - 89th. Avenue, Jamaica17. Burial 4/3/48 N.Y.  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Oak Lawn CemeteryLocation Baltimore, Md.18. Funeral director HENRY SANDER & SONS, INC  
NORTH AVE. & BROADWAY

Address

19. 4/2 48 A.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1948, at 11:00 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Coronary Occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? Home  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE M.B. Davis M.D.Address 16833 - 89th. Avenue, Jamaica  
Sp. Pt. Md. Date signed 4/3/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

108

02503

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 years, 9 months, 1 day  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 2 years, 9 months 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County.....  
City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 932 Preston Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### 3. (a) FULL NAME

James Kelly (Keller)

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife.....  
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) October 25, 1894  
8. AGE: Years 53 Months 4 Days 9 If less than one day hrs. min.

9. Birthplace..... Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation..... paper boy  
11. Industry or business same

12. Name William H. Keller  
13. Birthplace Washington, D.C.

14. Maiden name Margaret Amanda Hienlind  
15. Birthplace Washington, D.C.

16. Informant Hospital Records  
Address Catonsville 28, Md.

17. Burial Date thereof 3/9/48  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery Balto.  
Location " Md.

18. Funeral director William Cook Inc.  
Address 1217 St. Paul St.

19. March 9, 1948 A. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1948 at 8:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
and that I last saw him..... alive on.....

Immediate cause of death.....  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....  
Autopsy results..... as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?

23. SIGNATURE.....  
Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
How long in hospital or institution? 6 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 423 S. Chester Street  
(If rural, give LOCATION)  
2(a) If veteran, name war WW II

### 3. (a) FULL NAME

CHARLES D. KERR

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower  
6. (b) Name of husband or wife Widower  
7. Birth date of deceased (mo., day, yr.) 7-18-18 8. (c) If alive, give age  years  
8. AGE: Years 29 Months 7 Days 29 If less than one day  hrs.  min.  
9. Birthplace Pittsburgh, Pa.  
(Town, county, and state)  
10. Usual occupation Machinist  
11. Industry or business   
FATHER 12. Name Leo Kerr  
13. Birthplace Pennsylvania  
MOTHER 14. Maiden name Gertrude McKelvey  
15. Birthplace Pennsylvania

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Maryland  
17. Removal 3/8/48  
(Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)  
Edward Daughtery  
Cemetery or crematory 366 Lincoln Ave. at Fremont Bellevue  
Location Pittsburgh, Pa.  
18. Funeral director Howard Blight, Jr.  
Address 4914 Belair Rd., Baltimore, Md.  
19. March 11 19 48 John H. Connolly  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1948 at 10:20 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1948 to March 7, 1948 and that I last saw him alive on March 7, 1948  
Immediate cause of death Awaits completion of toxicological studies  
DURATION   
Due to Carbon tetrachloride poisoning [4/27/48 also]  
Anatomical diagnosis after autopsy  
Due to 1. Cerebral edema  
2. Pulmonary edema  
Other conditions 3. Cerebral necrosis in lower  
4. Cloudy swelling of kidneys  
(Include pregnancy within 3 months of death)  
5. Slight symmetrical hypertrophy of heart  
Major findings of operations   
Date of op.   
Autopsy results See above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

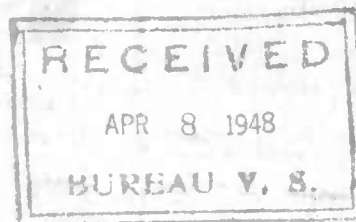
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Investigation by Date of   
Where did injury occur? Baltimore City, Police investigation  
(City or town) (County) (State) [4/26/48 also]  
Injured at home, farm, industry, public place (where?)   
Means of injury  Injured at work?   
23. SIGNATURE M B Davis MD  
Wm. J. Egan - Baltimore M. D. or other   
Address  Date signed 3/11/48

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Harrisonville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Harrisonville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Liberty Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Carrie Kimmel

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife late John L. Kimmel

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) November 22, 18648. AGE: Years 83 Months 3 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name George Nagle13. Birthplace Ind14. Maiden name Emma Brooks15. Birthplace Ind16. Informant Helen C. McKeeverAddress 1714 W. Lombard St.17. Burial Date there MAY 8, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rosson ParkLocation Balto. Ind18. Funeral director Harry A. WitzkeAddress 4101 Edmonstone Ave19. 3/7/48 Wm. E. Martin  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 5, 1948 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to Mar 2, 1948and that I last saw her alive on Mar. 4 1948Immediate cause of death Cardio Vascular Dis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm. E. Martin

M. D. or other

Address Randalltown Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

1917-1918

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

MEDICAL CERTIFICATE

RECEIVED

MAR 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02506

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)Street No. 119 Williams Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

David B. King Jr

## 3. (b) Social Security Number

216-07-25534. Sex Male 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Oct 17, 19148. AGE: Years 33 Months 4 Days 16 If less than one day  
..... hrs. .... min.9. Birthplace Baltimore  
(Town, county, and state)10. Usual occupation Boiler & fan operator11. Industry or business Steel Mill12. Name David B. King Jr13. Birthplace Matilda Bowes14. Maiden name Pa15. Birthplace Pa16. Informant Mrs. Matilda KingAddress 119 Williams Ave17. Burial Date thereof May 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Crest Lawn CemLocation Baltimore18. Funeral director Philips Herwig SonsAddress 2024 Orleans St19. 3-6-48 19. 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1948 at 5:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-14 1948 to 3-4 1948and that I last saw him alive on Feb 21 1948

Immediate cause of death

DURATION

Pulmonary Tuberculosis 5-yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE M.W. Jacobson M.D.

M. D. or other

Address 2310 Canton Place Date signed 3-6-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 8 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...City or town... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 17 West Hickam Road

(If rural, give LOCATION)

2. (a) If veteran, name war... WW II

## 3. (a) FULL NAME

HERBERT B. KIRTSCHER

## 3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Henrietta Kirtscher6. (c) If alive, give age 30 years7. Birth date of deceased (mo., day, yr.) 4-10-198. AGE: Years Months Days If less than one day  
28 11 0 hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Joseph Kirtscher13. Birthplace Maryland14. Maiden name Clara Mitchell15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. HospitalAddress Ft. Howard, Md.17. Burial Date thereat 3/15/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.Howard Blight, Jr.18. Funeral director Howard Blight, Jr.Address 4914 Belair Rd., Balto., Md.19. March 12, 48 A. W. Hedrick

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 48 at 11:25 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 48 to March 10, 48and that I last saw him alive on March 10, 48

Immediate cause of death

Hepatic Cirrhosis: Etiologyunknown

DURATION

Unknown

Due to

Due to

Other conditions Cellulitis & Hemorrhagicdiathesis of small intestine

(Include pregnancy within 8 months of death)

unknown

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. MANAUGHH. C. MANAUGH, M.D. Chief ProfessionalAddress VAH, Ft. Howard, Md. Date signed 3-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

163g

02508

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mt. Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs., 5 mos., 21 days  
 Hospital, institution, or street address where death occurred:  
Mt. Wilson Sanatorium  
 How long in hospital or institution? 2 yrs., 5 mos., 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery Co.  
 City or town Silver Springs  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9939 Moss Avenue.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Agatha Leaman

## 3. (b) Social Security Number

None

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Louis J. Simonton6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) June 1, 1901

8. AGE: Years 46 Months 9 Days -- If less than one day hrs. min.

9. Birthplace Washington, D. C.  
(Town, county, and state)10. Usual occupation Clerk

11. Industry or business

12. Name Oliver B. Leaman13. Birthplace Norbeck, Maryland14. Maiden name Mary K. Quilter15. Birthplace Washington, D. C.16. Informant Agatha LeamanAddress 9939 Moss Ave., Silver Springs,

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Mar. 4, 1948  
 (month) (day) (year)

Cemetery or crematory George Washington Cem.Location Hyattsville, Maryland18. Funeral director George Schwab Fun. HomeAddress 2101 Fred. Ave., Baltimore, Md.

19. Mar. 1, 1948 Earl T. Webster  
 (Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 19 48, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1-'48 to 3-1-'48

and that I last saw him/her not seen alive

Immediate cause of death Suicide-Codine Poisoning DURATION 2 hrs.

Due to

Due to

Other conditions Tuberculosis 23 yrs.(Pulmonary & Intestinal)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 3-1-'48Where did injury occur? Mt. Wilson, Balto., Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Mt. Wilson Sanat.Means of injury Self-adminis. Injured at work? No23. SIGNATURE Dr. D.D. Caples Med. Exam. M. D. or otherAddress Reisterstown, Md. Date signed 3-1-'48Rec'd - 3-9-48 - Dr. E.E. Nichols

CERTIFICATE OF DEATH

A form to be completed by a physician or other qualified person.

FILE NO.

MEDICAL CERTIFICATION

RECEIVED  
MAR 10 1948  
BUREAU V. S.  
RECEIVED  
MAR 10 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

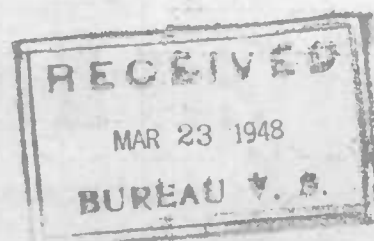
93d

02509

Reg. Dist. No. 4

<b>1. PLACE OF DEATH:</b> County... <u>BALTIMORE</u> City or town... <u>ARBUTUS</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>7 YRS.</u> Hospital, institution, or street address where death occurred: <u>1233 GREYSTONE ROAD</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State... <u>MD.</u> County... <u>BALTIMORE</u> City or town... <u>ARBUTUS</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>1233 GREYSTONE RD.</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>EMMA BARBARA LOECHEL</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>F.</u>		<b>5. Color or race</b> <u>W.</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>MARRIED</u>		<b>MEDICAL CERTIFICATION</b>	
<b>B. (b) Name of husband or wife</b> <u>JOHN H. LOECHEL</u>				<b>20. DATE OF DEATH</b> <u>14 MARCH</u> , 19 <u>48</u> , at <u>6:15</u> <u>P</u>			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>JUNE 22, 1886</u>				<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>19</u> to <u>19</u> and that I last saw him <u>alive</u> on <u>19</u>			
<b>8. AGE:</b> Years <u>61</u> Months <u>8</u> Days <u>22</u> If less than one day <u>hrs.</u> <u>min.</u>		<b>6. (c) If alive, give age</b> <u>years</u>		<b>Immediate cause of death</b> <u>Acute cardiac failure</u>			
<b>9. Birthplace</b> <u>BALTIMORE, MD.</u> (Town, county, and state)				<b>DURATION</b>			
<b>10. Usual occupation</b> <u>HOUSEWIFE</u>				<b>Due to</b> <u>Coronary vascular disease</u>			
<b>11. Industry or business</b>				<b>Other conditions</b>			
<b>FATHER</b>				(Include pregnancy within 3 months of death)			
<b>12. Name</b> <u>CARL A. ACHZIGER</u>				<b>Major findings of operations</b>			
<b>13. Birthplace</b> <u>BALTIMORE</u>				Date of op.			
<b>MOTHER</b>				<b>Autopsy results</b>			
<b>14. Maiden name</b> <u>ANNA F. SCHNOERR</u>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>15. Birthplace</b> <u>BALTIMORE, MD.</u>				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>			
<b>16. Informant</b> <u>MRS. G. FRED TREIBLER</u>				Accident, suicide, or homicide Date of			
Address <u>5017 LEEDS AVE, ARBUTUS</u>				Where did injury occur? (City or town) (County) (State)			
<b>17. BURIAL</b> (Burial, cremation, or removal. Which?) Date thereof <u>MARCH 17, 1948</u> (month) (day) (year) Cemetery or crematory <u>London Park</u> Location <u>Frederick Ave. Baltimore, Md.</u>				Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
<b>18. Funeral director</b> <u>Walter Burke Bradley</u> Address <u>1922 W. North Ave - Baltimore</u>				<b>23. SIGNATURE</b> <u>Dr. M. Kieffer</u> <u>Edna Kieffer</u> M. D. or other			
<b>19. Filed</b> <u>14</u> <u>48</u> <u>Dr. Kieffer</u> (Date rec'd by registrar) Registrar				Address <u>1010 Leeds Ave</u> Date signed <u>3-14-48</u>			

*Miller*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02510  
38  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County BALTIMORE  
City or town RUXTON MALVERN AVE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State M.D. County BALTO  
City or town RUXTON  
(If outside city or town limits, write RURAL and give nearest town)Street No. MALVERN AVE  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARY MAY LONG

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## B. (a) Single, married, widowed, or divorced

WIDOWED

## 6. (b) Name of husband or wife

THOMAS S. LONG

## 7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

MAY 5, 1866

## 8. AGE:

Years

81

Months

10

Days

12

If less than one day

hrs.

min.

## 9. Birthplace

RIDGEVILLE, W. Va.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

## 12. Name

JAMES H. TRAUT

## 13. Birthplace

RIDGEVILLE, W. Va.

## MOTHER

## 14. Maiden name

SUSAN JANE CALDWELL

## 15. Birthplace

SPRINGFIELD W. Va.

## 16. Informant

MR. WM. H. LONG

## Address

6308 BELLONA AVE

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

3/20/48  
(month) (day) (year)

## Cemetery or crematory

DRUID RIDGE

## Location

TIKESVILLE MD.

## 18. Funeral director

WM. J. TIGHER & SONS

## Address

BALTIMORE, MD.

## 19.

3/20

19

48H. W. Hedrick

Registrator

D-2

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17/48 1948 at 11 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 1948 to Mar 17 1948and that I last saw him alive on Mar 17 1948

## Immediate cause of death

## DURATION

Tuberculosis (pulmonary) inh.

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State) .....

Injured at home, farm, industry, public place (where?) .....

## Means of injury

## Injured at work?

## 23. SIGNATURE

John Hedrick, M.D.Address Baltimore, Md. Date signed 3/19/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02511

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County Balto.City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war World War 1 & 2

## 3. (a) FULL NAME

Leon William Macdonald

## 3. (b) Social Security Number

064-03-3625

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Married</u>

6. (b) Name of husband or wife Bernice H. Macdonald7. Birth date of deceased (mo., day, yr.) Aug. 7, 1895

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>7</u>	<u>20</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace Brownsville Junction, Maine  
(Town, county, and state)10. Usual occupation Industrial Sales Engineer

## 11. Industry or business

12. Name John R. Macdonald13. Birthplace Plainfield Vermont14. Maiden name Josephine Barbe15. Birthplace Switzerland16. Informant Bernice H. MacdonaldAddress Reisterstown, Md.17. Burial Date thereof March 31, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cambridge CemeteryLocation Cambridge Mass.18. Funeral director J. F. Eline & SonsAddress Reisterstown, Md.19. 3-29-48 Mary B. Eline  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 27 19 48 at 10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-16 19 38 to Mar 27 19 48.  
and that I last saw him alive on 3-27 19 48.Immediate cause of death Edema of lungs DURATION 4 mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of \_\_\_\_\_Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE D. D. Caples, M. D. M. D. or otherAddress Reisterstown, Md. Date signed 3-29-48

**RECEIVED**  
MAR 31 1948  
BUREAU V. S.

4-24-

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02512

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 yrs.  
 Hospital, institution, or street address where death occurred:  
25 Sherwood Ave.  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 25 Sherwood  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Ellis Jerome Mahon

## 3. (b) Social Security Number

215-01-6790

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Divorced

## 6. (b) Name of husband or wife

Marion Mahon

## 7. Birth date of deceased (mo., day, yr.)

May 14, 1891

## 6. (c) If alive, give age

36 years

## 8. AGE:

Years

Months

Days

If less than one day

56923

hrs.

min.

## 9. Birthplace

Detroit, Michigan  
(Town, county, and state)

## 10. Usual occupation

machinist

## 11. Industry or business

unemployedFATHER  
MOTHER

## 12. Name

Frank Ellis Mahon

## 13. Birthplace

Canada, (Ontario)

## 14. Maiden name

Mary E. Downer

## 15. Birthplace

Wayne Co. Michigan

## 16. Informant

Mrs. Joseph Gardner

## Address

1004 Bristlestown Rd Pikesville, Md

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

March 9, 1948  
(month) (day) (year)

## Cemetery or crematory

Druid Ridge

## Location

Pikesville, Md

## 18. Funeral director

Frank A. Newell

## Address

Pikesville, Maryland

## 19.

2-7-  
(Date rec'd by registrar)

19

48E.E. Nichols

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7 March 1948 at 2:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 7 March 1948and that I last saw him alive on 19Immediate cause of death cardiorespiratory failure

## DURATION

Due to hypertensive cardiovascular renal disease4 yrs.Due to —Other conditions Doc Peptic ulcer, healed 10 yrs?

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —

## 23. SIGNATURE

Paul H. Royce M.D.

M. D. or other

Address Pikesville 8, Md Date signed 8 Mar 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 9 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

### 1. PLACE OF DEATH:

County BALTIMORE

City or town WHITE HALL  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 53 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTIMORE

City or town WHITE HALL  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

MARGARET ANN MARKLINE

### 3.(b) Social Security Number

NONE

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE WIDOW

6.(b) Name of husband or wife PHILIP MARKLINE

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) DECEMBER 3 - 1862

8. AGE: Years Months Days If less than one day  
85 3 9 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace WHITE HALL MD  
(Town, county, and state)

10. Usual occupation AT HOME

11. Industry or business

12. Name MICHAEL KING

13. Birthplace BARBARA GERMANY

14. Maiden name CATHERINE STROH

15. Birthplace BALTIMORE Co. MD

16. Informant Howard S. Markline

Address White Hall, MD

17. BURIAL Date thereof MAR-14-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory VERNON

Location WHITE HALL R.F.D.

18. Funeral director E. B. Kuntz

Address Gaithersburg, Md.

19. Mar. 13, 19 48 Mrs. Howard S. Markline  
(Date rec'd by Registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 12 19 48 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
19 38, to Mar. 12 19 48  
and that I last saw him alive on Mar. 11 19 48

Immediate cause of death Chronic myocarditis DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Thyroidism  
arterio-sclerosis  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. W. France M. D. or other \_\_\_\_\_

Address Parkton, Md. Date signed 3/11/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02514

Reg. Dist. No. 938

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since February 27, 1948

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson, Md.How long in hospital or institution? Since Feb 27, 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 N. Eylesme  
(If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Michael Mastrecola MASTRECOLA

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife Eva D. Mastrecola7. Birth date of deceased (mo., day, yr.) July 28, 18948. AGE: Years 53 Months 7 Days 13 If less than one day

8. (c) If alive, give age \_\_\_\_\_ years

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Engineer11. Industry or business Sparrows Point12. Name John Mastrecola13. Birthplace Italy14. Maiden name Josephine Jackson15. Birthplace Canada16. Informant Personal history-Hospital recordsAddress Eudowood Sanatorium, Towson, Md.17. Burial 3/15/48  
(Burial, cremation, removal, which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Balto. Md.18. Funeral director William Cook Inc.Address 1217 St. Paul St.19. Mar 12 1948 A.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1948 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 27, 1948 to March 11, 1948and that I last saw him alive on March 11, 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pulmonary tuberculosisDue to \_\_\_\_\_ Since 1945

Due to \_\_\_\_\_

Other conditions Full of fear just aboutbefore dying apparently 4:45 A.M.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. J. Bridges M. D. D.M.E.Address Towson, Md. Date signed 3-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

21 Melrose Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 21 Melrose Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Thomas Matthews

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleColoredWidower

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 10, 18808. AGE: Years 67 Months 8 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Catonsville, Md.  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Charles Matthews13. Birthplace Md.14. Maiden name Marie Bowen15. Birthplace Md.18. Informant Mrs. Mable CurtissAddress 21 Melrose Ave.17. Burial Date thereof 3-6-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Western Star Cem.Location Catonsville, Balto., No., Md.18. Funeral director Mrs. Frances A. HemsleyAddress 578 W. Biddle St.19. 3/4 (Date rec'd by registrar)19. x 8L. W. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2nd 1948 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-10-48 19. to 3-2-48 19.and that I last saw him alive on 3-2-48 19.

Immediate cause of death

DURATION

Mitral Insufficiency?

Due to

Arteriosclerosis?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address B. F. Maloney MD  
Catonsville, Md. Date signed 3/4/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

02516

44

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH *Balto.*  
 County.....  
 City or town.....*Sparrow Point*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred.....  
*819 East E. St.*  
 How long in hospital or institution?.....*50 years*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Josephine Mc Donough.*

## 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*  
 6.(b) Name of husband or wife *Thomas Mc Donough.*

7. Birth date of deceased (mo., day, yr.) *Oct 20/1885.*  
 6.(c) If alive, give age..... years

8. AGE: Years *62* Months *5* Days *1* If less than one day  
 hrs. .... min.

9. Birthplace..... *Balto City.*  
 (Town, county, and state)

10. Usual occupation..... *Wife*

11. Industry or business..... *at home.*

12. Name..... *Thomas Greely.*

13. Birthplace..... *Ireland.*

14. Maiden name..... *Julia Flaherty.*

15. Birthplace..... *Ireland.*

16. Informant..... *Mr. Julia Flynn (Daughter)*

Address..... *128 Dunkirk Rd. Balto Md*

17. *Burial* Date thereof..... *3-24-48*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Holy Redeemer*

Location..... *4430 Belair Rd*

18. Funeral director..... *John A. Moran*

Address..... *3000 E. Balt. St.*

19. *Mar 22 48* *L. Lawrence L. Harbor*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Mar 21 48* at *1 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 ..... 19..... to ..... 19.....  
 and that I last saw him..... alive on ..... 19.....

Immediate cause of death.....  
*Strangulation by hanging.*  
 Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

22. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

*Suicide* Date of *3/21/48*  
 Accidental suicide, or homicide

Where did injury occur? *Sparrow Pt. Balto. Md.*  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *at home*

Means of injury *Hanging by rope* Injured at work? *at home*

23. SIGNATURE..... *J. Mc Donough M.D.*  
 Deputy Medical Examiner

Address..... *Balto. Co. Dunkirk Rd 3/21/48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County BaltimoreCity or town Bundalk  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

1725 Church Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Bundalk  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1725 Church Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Laura Isabelle McGinley

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Philip Cooper McGinley

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 20 April 1873

## 8. AGE:

Years

Months

Days

If less than one day

751010

hrs.

min.

9. Birthplace Somerset County, Pennsylvania  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Charles ~~Mc~~ Caldwell13. Birthplace England14. Maiden name Emma Mae Hockenberry15. Birthplace Pennsylvania16. Informant Mrs. Ruth ThorneAddress 1725 Church Road17. Burial 3/4/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Bellefonte, Pa.18. Funeral director HENRY SANDER & SONS, INC.Address NORTH AVE. & BROADWAY19. 3/3 48 R. W. Hedrick  
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 March 48 at 8:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19. 46 to 1 March 19. 48and that I last saw him 23 Feb. alive on 19. 48

Immediate cause of death

Carcinoma of sigmoid

DURATION

2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bernard W. Sawick  
M. D. or otherAddress 8 Liberty Parkway Date signed 1 March '48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

131a 02519

Reg. Dist. No. 42

### I. PLACE OF DEATH:

County Baltimore

City or town Lansdowne  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yr.

Hospital, institution, or street address where death occurred:  
5911 Hammocks Ferry Rd.

How long in hospital or institution? .....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Bolton

City or town Lansdowne  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2911 Hammocks Ferry Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

### 3. (a) FULL NAME

James Miller

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

8.(b) Name of husband or wife Emma D. Miller

7. Birth date of deceased (mo., day, yr.) April 18 - 1861 5.(c) If alive, give age .....

8. AGE: Years 86 Months 10 Days 26 If less than one day .....

9. Birthplace Austria  
(Town, county, and state)

10. Usual occupation Ret.

11. Industry or business .....

12. Name Unknown

13. Birthplace Austria

14. Maiden name Unknown

15. Birthplace Austria

16. Informant James Platt

Address 205 Hillenobal Rd, Lansdowne

17. Burial Date thereof May 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Cem.

Location Baltimore Md.

18. Funeral director Dill Bros.

Address 3109 Frederick Ave.

19. 3/16 19 48 DW Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 48 at 6:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 47 to Mar. 15 19 48

and that I last saw him alive on Mar. 15 19 48

Immediate cause of death Coronary Insular Renal Disease

Due to .....

Due to Arterio-sclerosis

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr M. D. or other

Address Linthicum Date signed 3-15-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02520

93d

Reg. Dist. No. 17

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Cockeysville (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Jake Rd.  
 (If rural, give LOCATION)  
 2.(c) If veteran, name war No

## 3. (a) FULL NAME

Mary Ellen Miller

## 3. (b) Social Security Number

None

## 4. Sex

F.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Married

## 8. (b) Name of husband or wife

Harry C. Miller

## 7. Birth date of

deceased (mo., day, yr.)

Mar. 6, 1864

## 6. (c) If alive, give age

80 years

## 8. AGE:

Years

Months

Days

If less than one day

83413

hrs.

min.

## 9. Birthplace

Balto. Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Wm. Carter

## 13. Birthplace

Balto. Co. Md.

## 14. Maiden name

Roseella Parker

## 15. Birthplace

Balto. Co. Md.

## 18. Informant

Harry C. Miller

## Address

Cockeysville R #1

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Mar. 22, 1948  
(month) (day) (year)

## Cemetery or crematory

Poplar Grove Church Cem.

## Location

Cockeysville, Md.

## 18. Funeral director

Landin & Sons, Brooks

## Address

Sparks, Md.

## 19.

(Date rec'd by registrar)

5 -20- 48Wilmer C. Benson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 19 48 at 11:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 23 19 47 to March 18 19 48and that I last saw h... C.R. alive on March 15, 1 19 48

Immediate cause of death

Coronary thrombosis

DURATION

1-2 days

Due to

hypertensive - arterio-sclerotic  
cardio-vascular diseasemany years

Due to

Other conditions Pernicious anemiayears

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

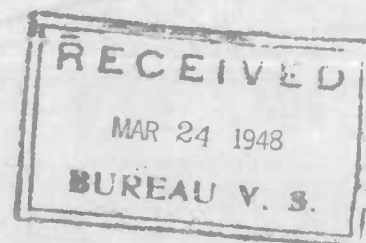
Injured at work?

23. SIGNATURE

Elizabeth B. Sherrill 1213d

M. D. or other

Address Cockeysville, Md. Date signed 3/30/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02521

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:  
County Back River Neck Rd. Essex, Md.City or town Rural - Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Essex - Rural Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. Box 406 Back River Neck Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EDWARD WILLIAM MOROZ

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1913

8. AGE:

Years

Months

Days

If less than one day

34

11

18

hrs.

min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

Sparrow Point

FATHER

12. Name Albert Moroz

13. Birthplace Poland

MOTHER

14. Maiden name Justine Williki

15. Birthplace Poland

16. Informant Mrs. Anna Brehm

Address Ex. 406 Back River Neck Rd. Essex

17.

Burial Date thereof 3/4/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ Evangelical Church Cem.

Location Dundalk, Md.

18.

HENRY SANDER &amp; SONS, INC.

16. Funeral director

Address NORTH AVE. &amp; BROADWAY

19.

3/3 48 A.W. Hedrick  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 5.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 4 1947 to March 1 1948  
and that I last saw him alive on March 1 1948

Immediate cause of death

DURATION

Pulmonary hemorrhage 2 weeks

Due to Pulmonary Tuberculosis 10 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address 422 Eastern Ave. Date signed 3/2/48

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02522

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Cockeysville, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 days  
 Hospital, institution, or street address where death occurred:  
Masonic Home  
 How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County...  
 City or town... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 2520 Sheppard Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Mr. Frank Morris  
 4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

## 3. (b) Social Security Number

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15 - 1872

8. AGE: Years 75 Months 4 Days 15 If less than one day  
 hrs. min.

9. Birthplace Birmingham England  
(Town, county, and state)10. Usual occupation Stocker

11. Industry or business

12. Name Don't know

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Laura M. SchraederAddress Masonic Home, Cockeysville, Md17. Burial Date thereof 4 - 2 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Baltimore Md.18. Funeral director Hon. CookAddress St. Paul & Preston St19. 3/31 19 48 Laura M. Schraeder  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 30 19 48 at 11:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 26 19 48 to Mar 30 19 48  
 and that I last saw him alive on Mar 30 19 48

Immediate cause of death... Coronary Thrombosis DURATION 1 day

Due to... Arteriosclerosis 5 yrs

Due to...  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Walter J. Kees M.D. M. D. or other  
 Address Cockeysville Md Date signed 3/30/48

RECEIVED

APR 1 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

181

02523

92

## CERTIFICATE OF DEATH

Reg. Dist. No.

### 1. PLACE OF DEATH:

County Baltimore  
City or town Milford  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr.  
Hospital, institution, or street address where death occurred: no  
How long in hospital or institution? ✓

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Milford  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Durley Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war no

### 3. (a) FULL NAME

Alice Esther Black Mowbray

### 3. (b) Social Security Number

none

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Edwin R. Mowbray

7. Birth date of deceased (mo., day, yr.) August 14 - 1898 6.(c) If alive, give age 51 years

8. AGE: Years 49 Months 7 Days 11 If less than one day hrs. min.

9. Birthplace Baltimore County, Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Black

13. Birthplace Baltimore County, Md.

14. Maiden name Mary Ellen Harvey

15. Birthplace Olaure

16. Informant Edwin R. Mowbray

Address Durley Ave. Milford Balt. Co. Md.

17. Burial, cremation, or removal, which? Burial Date thereof 3/27/48  
(month) (day) (year)

Cemetery or crematory Mt. Oliv.

Location Randallstown, Md.

18. Funeral director Frank H. Newell Inc.

Address Pikesville, Maryland

3-29-48 19 48 Dr. E. E. Nichols  
(Date rec'd by registrar) new Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 48 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-25-48 to 3-25-48 and that I last saw her alive on not seen alive

Immediate cause of death Second & third degree burns of entire body  
Due to thr. (est.)

Due to  
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results NONE  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Accident Date of 3-25-48  
Where did injury occur? Durley Ave - Balt. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fire in Residence Injured at work?

23. SIGNATURE Dr. D. D. Caples Med. Exam.  
M. D. or other

Address Reisterstown, Md. Date signed 3-25-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 29 1913

BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

02524

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Baltimore  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....Life  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....md..... County.....Balti.....  
City or town.....Lourey.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME.....John Henry Myers.....

3. (b) Social Security Number.....

4. Sex.....M...... 5. Color or race.....Col..... 6.(a) Single, married, widowed, or divorced.....married.....

6.(b) Name of husband or wife.....Fannie.....

6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.).....Sept 24, 1899.....

8. AGE: Years.....48..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....Balti County.....  
(Town, county, and state)

10. Usual occupation.....Labourer.....

11. Industry or business.....

FATHER 12. Name.....Phillip Myers.....

13. Birthplace.....md.....

MOTHER 14. Maiden name.....Lucy ?.....

15. Birthplace.....md......

16. Informant.....Fannie Myers.....

Address.....Lourey Md.....

17. Burial..... Date thereof.....March 13/48.....  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Arbary Cemetery.....

Location.....Lourey Md.....

18. Funeral director.....Mrs. Rott, A. Elliott & Co.....

Address.....1129 N. Caroline St......

19. 3-10..... 19 48..... A. W. Halrich.....  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 9..... 19 48..... at 3:45..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....Feb 16..... 19 48..... to March 9..... 19 48.....  
and that I last saw him alive on.....March 9..... 19 48.....

Immediate cause of death.....Cerebral hemorrhage.....

DURATION.....3 weeks.....

Due to.....generalized arteriosclerosis.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Jed O Hodors MD.....  
M. D. or other

Address.....Edgewood Md..... Date signed.....3-9-48.....

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Cockeysville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 Years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Cockeysville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. John Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Nancy Susan Myres

### 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Alexander J. Myres

7. Birth date of deceased (mo., day, yr.) May 3, 1856 6. (c) If alive, give age years

8. AGE: Years 91 Months 9 Days 27 If less than one day hrs. min.

9. Birthplace Hellersburg, Pa.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name David J. Smith

13. Birthplace Pennsylvania

14. Maiden name Elizabeth Cousen

15. Birthplace Penn.

16. Informant C. W. Bogart

Address Cockeysville, Md.

17. Burial Date thereof May 5, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Guard

Location Guard Ohio

18. Funeral director Landon M. Brooks

Address Sparks, Md.

19. Mar. 2, 48 Wilmer C. Ensor  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1948, at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 1948, to March 1 1948

and that I last saw her alive on March 1 1948

Immediate cause of death Myocarditis, Chronic

Other condition Cerebral Embolism

advanced age  
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. G. de Puy

M. D. or other

Address Cockeysville, Md. Date signed 3/2/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

02526

## 1. PLACE OF DEATH:

County BALTIMORECity or town ESSEX  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? ?

Hospital, institution, or street address where death occurred:

630 FRANKLIN AVE.How long in hospital or institution? ?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORECity or town ESSEX  
(If outside city or town limits, write RURAL and give nearest town)Street No. 630 FRANKLIN AVE.  
(If rural, give LOCATION)2.(a) If veteran, name war ?

## 3. (a) FULL NAME

MICHAEL NOPPINGER SR.

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WIDOWED

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 6 - 19 48, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7:00 20 19 48, to March 6 19 48  
and that I last saw him alive on March 6 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

HypertensionNot Known

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. A. Jacobs M.D.Address 617 North 1st Rd M. D. or other 3/9/48  
Date signed6. (b) Name of husband or wife BARBARA FOERTSCH

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

AUGUST 27, 1873

8. AGE:

Years

Months

Days

If less than one day

7479

hrs.

min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual occupation

RETIRED POLICEMAN

11. Industry or business

MOTHER FATHER

12. Name

JOHN NOPPINGER

13. Birthplace

GERMANY

14. Maiden name

?

15. Birthplace

?

16. Informant

NICHOLAS NOPPINGER

Address

630 FRANKLIN AVE - ESSEX

17. (Burial, cremation, or removal. Which?)

BURIAL

Date thereof

3-10-48

(month) (day) (year)

Cemetery or crematory

SACRED HEART CEM.

Location

GERMAN HILL RD. BALTO. CITY

18. Funeral director

LILLY & ZEILER INC.

Address

403 S. WOLFE ST. BALTO.

19. (Date rec'd by registrar)

March 9 1948

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH

County Baltimore  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? \_\_\_\_\_  
 Hospital, institution, or street address where death occurred: \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Featherbed Lane  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Lou Griffin Parker

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Clyde Parker  
 7. Birth date of deceased (mo., day, yr.) Jan. 8, 1903 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 45 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Butman Co. La.  
 (Town, county, and state)

10. Usual occupation Seventeen

11. Industry or business \_\_\_\_\_

12. Name Henri Griffin13. Birthplace Butman Co. La.14. Maiden name Mattie Williams15. Birthplace Butman Co. La.16. Informant Mrs. Clyde ParkerAddress Featherbed Lane17. Burial Burial Date thereof March 22, 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Family lotLocation Atlanta, Ga.18. Funeral director Mrs. G. W. H. HollandAddress 1631 David Hill Ave19. Mar 22, 1948 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1948 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1948 to Febr. 25, 1948  
 and that I last saw him alive on March 23, 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Due to \_\_\_\_\_

\_\_\_\_\_

Due to \_\_\_\_\_

\_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Operation was done inHopkins Hospital Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

\_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

\_\_\_\_\_

23. SIGNATURE J. Walker Lunsford, M.D.Address 23 Hanover Rd. Date signed 8/22/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02528

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Baltimore Co.  
City or town Owings Mills, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 16 yrs. 1 mo., 1 day.  
Hospital, institution, or street address where death occurred:  
Rosewood St. Training School.  
How long in hospital or institution? 16 yrs. 1 mo., 1 day.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Caroline  
City or town Easton Denton  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Edward Bayward Patchett

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife \_\_\_\_\_  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 12/26/16  
8. AGE: Years 31 Months 2 Days 8 If less than one day 5 hrs. 10 min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH 3/5/48 19 48 at 5.10A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 19 48 to March 6 19 48  
and that I last saw him alive on March 6 19 48

Immediate cause of death Cardiac insufficiency (aortic lesion) DURATION 8 yrs.

Due to Hemiplegic Idiot with symptomatic grand mal epilepsy. Birth  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Harry B. Butler M. D. or other \_\_\_\_\_

Address Owings Mills, Md. Date signed 3/6/48

9. Birthplace Easton, Maryland  
(Town, county, and state)  
10. Usual occupation Inmate Rosewood St. Training School.  
11. Industry or business \_\_\_\_\_  
12. Name John Patchett  
13. Birthplace Talbot Co., Md.  
14. Maiden name Adele Asche  
15. Birthplace Nebraska  
16. Informant Institutional Records  
Address Rosewood, Owings Mills, Md.  
17. Burial Burial Date thereof March 7, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rosewood Cemetery  
Location Balto. Co.  
18. Funeral director J. F. Eline & Sons  
Address Reisterstown, Md.  
19. 3-7 19 48 Mary B. Eline  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 16 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH.

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02529

Reg. Diat. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr.  
 Hospital, institution, or street address where death occurred: \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 22 Walker  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Allen Francis Peddicord

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Helin Ruth Peddicord  
 7. Birth date of deceased (mo., day, yr.) May 7 - 1915 8. (c) If alive, give age 31 years  
 8. AGE: Years 32 Months 10 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Waynesborough - Pa.  
 (Town, county, and state)

10. Usual occupation Silversmith

11. Industry or business Stieff Co.

12. Name Joseph Peddicord

13. Birthplace Maryland

14. Maiden name Adeline Krietz

15. Birthplace Maryland

16. Informant Mrs. Allen F. Peddicord

Address 22 Walker Ave. Pikesville, Md

17. Burial Date thereof April 1 - 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Catholic

Location Baltimore, Md

18. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. 3/3/11 19 48 EE Nichols  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 March 1948 at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 March 1948 to 29 March 1948

and that I last saw him alive on 29 March 1948

Immediate cause of death cardio-respiratory failure

Due to hypertensive cardiovascular disease

Due to renal disease

Other conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul & Payne M.D.

Address 211 Church Lane Pikesville, Md Date signed 29 March 1948

\_\_\_\_\_ M. D. or other

\_\_\_\_\_ Date signed \_\_\_\_\_

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS DEPARTMENT OF HEALTH

1001 A. Comm. 1001B. 1001C.

CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF REPORT

REPORTED BY

SIGNATURE

PRINTED NAME

ADDRESS

CITY

STATE

COUNTY

ZIP CODE

TELEPHONE

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RECEIVED

APR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information known. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

186a 02530

Reg. Diat. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year 8 months

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 1 year 8 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CharlesCity or town Ironside  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Robert C. Perry

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteSingle

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) December 16, 19028. AGE: Years Months Days If less than one day  
45 2 15 hrs. min.9. Birthplace Ironside, Maryland  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Agriculture12. Name Milton Perry13. Birthplace Maryland14. Maiden name Novella Sanders15. Birthplace Maryland16. Informant Hospital RecordsAddress Catonsville 28, Md.17. Buried Date thereof 3-29-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring Grove State HospitalLocation Catonsville 28, Maryland18. Funeral director Spring Grove State HospitalAddress Catonsville 28, Md.19. 3-29-48 V.E. Harry  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 19 48 at 10:10 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Congestion PneumoniaDue to fracture left hipOther conditions surgical neckaccident

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Feb 21, 48Where did injury occur? Catonsville, Balt. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) hospitalMeans of injury pushed on crushed down by another patient Injured at work? noSignature Geo. M. Kieffer Deaf MedAddress 1010 Leedsian Date signed 3-2-48

**RECEIVED**

MAR 30 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02531

Reg. Dist. No. XX

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Day  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
 How long in hospital or institution? 1 Day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 125 Cheapside St.  
 (If rural, give LOCATION)  
WW-I  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOSEPH A. PLANK

## 3. (b) Social Security Number

Unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widower</u>	
6. (b) Name of husband or wife <u>Widower</u>			
7. Birth date of deceased (mo., day, yr.) <u>12-24-1888</u>			
8. AGE: Years <u>59</u>	Months <u>2</u>	Days <u>23</u>	If less than one day .....hrs. ....min.

6. (c) If alive, give age ..... years

9. Birthplace Pennsylvania  
 (Town, county, and state)  
 10. Usual occupation Unemployed  
 11. Industry or business \_\_\_\_\_

FATHER	12. Name <u>Joseph Plank</u>
	13. Birthplace <u>Pennsylvania</u>
MOTHER	14. Maiden name <u>Unknown</u>
	15. Birthplace <u>Pennsylvania</u>

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland

17. Burial Date thereof 3/19/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
Baltimore, Md.  
 Location Howard W. Blight, Jr.  
Howard Blight, Jr.  
 18. Funeral director 4914 Belair Rd., Baltimore, Md.  
 Address \_\_\_\_\_

19. 3/18 1948 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1948 at 8:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 16, 1948, to March 17, 1948  
 and that I last saw him alive on March 17, 1948

Immediate cause of death Pulmonary Tuberculosis, far adv., active.  
 DURATION Many years.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George Leiner M. D. or otherAddress V.A.H. FT. HOWARD, MD. Date signed 3-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore  
CERTIFICATE OF DEATH

02532

112

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County... Baltimore  
City or town... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 days  
Hospital, institution, or street address where death occurred:  
Veterans Administration Hospital  
How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County.....  
City or town... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 911 N. Central Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW

## 3. (a) FULL NAME

HARRISON PLANTER

## 3. (b) Social Security Number

?

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Helen Planter  
6.(c) If alive, give age 42 years  
7. Birth date of deceased (mo., day, yr.) August 3, 1893  
8. AGE: Years 54 Months 7 Days 21 If less than one day  
.....hrs. ....min.

9. Birthplace... Baltimore, Md.  
(Town, county, and state)10. Usual occupation... Unemployed

## 11. Industry or business

12. Name... Stephen Planter  
13. Birthplace ?  
14. Maiden name Ellen ?  
15. Birthplace ?

16. Informant Clinical Records, Vet. Adm. Hosp.  
Address Fort Howard, Maryland

17. Burial Date thereof 3/27/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Baltimore National Cemetery  
Location Baltimore, Md.

18. Funeral director Charles R. Law  
Address 802 Madison Ave., Balto., Md.

19. 3-25-48 H. W. Hedrich  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 48 at 5:40 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 9 19 48 to March 24 19 48  
and that I last saw him alive on March 24 19 48

Immediate cause of death BRONCHIAL ASTHMADURATION  
Unknown

Due to.....

Due to.....

Other conditions Cor Pulmonale Unknown

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results... Substantiated Above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE J. Alvarez M. D. or other  
Address VAH Fort Howard, Md. Date signed 3-24-48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02533

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County BaltimoreCity or town Holoh Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Holoh Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sister Mary Pauline Pohl

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

B.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

T. Birth date of deceased (mo., day, yr.) Oct 1, 18668. AGE: Years Months Days If less than one day  
81 5 8 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Muehlisburg, Germany  
(Town, county, and state)10. Usual occupation Teacher

11. Industry or business \_\_\_\_\_

FATHER 12. Name Paul Pohl13. Birthplace GermanyMOTHER 14. Maiden name Wilhelmina Gieseler15. Birthplace Germany16. Informant S. Mary ClaraAddress Holoh Cliff, Md17. Burial Date thereof Mar 12/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or cremator Notch CliffLocation Gen M. Friedman18. Funeral director 811 N. M. Friedman

Address \_\_\_\_\_

19. March 10, 48 Halter M. Friedman  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 9 1948 at 1:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec 17 1946 to March 9 1948  
and that I last saw her alive on March 8 1948Immediate cause of death Myocardial decomposition

## DURATION

about 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arterio sclerosis unknown

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Halter M. Friedman M. D. or otherAddress Towson Date signed March 4/48

RECEIVED

MAR 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

EVIDENCE FOR ADDITION OF  
CAUSE OF DEATH (S ON)  
FILM No. G 119 MAR 29 1949

## CERTIFICATE OF DEATH

163 B 02534

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 hrs. 40 minutes

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 11 hrs. 40 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County

City or town... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1511 Bolton Street

(If rural, give LOCATION)

2.(a) If veteran, name war... WW II

## 3. (b) Social Security Number

## 3. (a) FULL NAME

JOHN H. POWELL

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife... Single

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

12-19-24

8. AGE:

Years

Months

Days

If less than one day

2337

hrs.

min.

9. Birthplace... Baltimore, Maryland

(Town, county, and state)

10. Usual occupation... Unemployed

11. Industry or business

FATHER

12. Name... Charles Powell13. Birthplace... Virginia

MOTHER

14. Maiden name... Jane Harrison15. Birthplace... Maryland16. Informant... Clinical Records, Vets. Adm. HospitalAddress... Fort Howard, Maryland

17. Burial (Burial, cremation, or removal, Which?)

Date thereof... 3/30/48  
(month) (day) (year)Cemetery or crematory... Baltimore National CemeteryLocation... Baltimore, Maryland18. Funeral director... Howard H. Blight Jr.Address... 4914 Belair Rd., Baltimore, Md.

19. (Date rec'd by registrar)

19. 48DW. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 26 19 48 at 10:40 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

March 2619 48to March 2619 48and that I last saw him alive on March 26 19 48

Immediate cause of death

Awaits Toxicologic examinationBarbiturate Poisoning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results... See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... suicide

Date of

(3/29/49) - AMS

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

3/27/49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02535

Reg. Dist. No.

38-

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural near Cockeysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Rural near Cockeysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. near Butler  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Elenora Price

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow.6. (b) Name of husband or wife George H Price7. Birth date of deceased (mo., day, yr.) January 1, 1864 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 84 Months 2 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Manchester Md. R.D.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Yost13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Emma A. NelsonAddress Cockeysville Md. R.D.17. Burial Date thereof March 19, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Shaffers CemeteryLocation Glen Rock, York Co., Penna.18. Funeral director Jacob HartmanAddress New Freedom Pa.19. Mar. 18 1948 White S. Fisher  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1948 at 11:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-17 1940, to 3-16 1948  
and that I last saw her alive on 3-14 1948

Immediate cause of death

arteriosclerosis E.-V. Disease 8 yrs.  
Infected Bed Sores 3 wks.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Chr. Cholecystitis 8 yrs.  
arthritis 8 yrs.  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Antopsy results None Date of op. \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? None  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE D. D. Caples M.D. M. D. or other \_\_\_\_\_Address Reisterstown Md. Date signed 3-17-48

RECEIVED

MAR 28 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02536

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balto.  
City or town Rosedale  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.R. tracks B&O. 1 1/2 mile west of Rosedale Sta.

How long in hospital or institution?

## 3. (a) FULL NAME

James Price

4. Sex

Male

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

About 28

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial  
(Burial, cremation, or removal. Which?)

Date thereof

3-4-48  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 2 48 at 5:36 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

DURATION

Compound fracture  
Crushed frontal skull  
Due to  
Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3/2/48Where did injury occur? Rosedale, Balto. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Rail roadMeans of injury Hit by train Injured at work? no

23. SIGNATURE

M. D. or other  
Deputy medical examiner  
Address Balto Co. DuPont St Date signed 3/2/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 8 1961

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12537

46a

44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 117 days

Hospital, institution, or street address where death occurred:

VAH Fort Howard, MarylandHow long in hospital or institution? 117 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
4288 (If outside city or town limits, write RURAL and give nearest town)Street No. 4288 Edgehill Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war WW I

## 3. (a) FULL NAME

GEORGE B. ROBERTS

## 3. (b) Social Security Number

216-07-6464

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single7. Birth date of deceased (mo., day, yr.) 10-7-1886

8. AGE: Years Months Days If less than one day

61 5 20 hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and State)10. Usual occupation Watchman11. Industry or business H.12. Name James Roberts13. Birthplace Maryland14. Maiden name Ruth Airey15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. HospitalAddress Fort Howard, Maryland17. Burial Date thereof March 31-1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn CemeteryLocation Baltimore, Maryland18. Funeral director Burgee Funeral HomeAddress 3631 Falls Rd., Baltimore, Md.19. 3/29 48 R.W. Hedrick Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 48 at 10:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 1 19 47 to March 27 19 48and that I last saw him alive on March 27 19 48Immediate cause of death CARCINOMA OF ESOPHAGUS

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE JOSEPH H. SAUNDERS, M.D.  
M. D. or otherAddress V.A.H. FORT HOWARD, MD. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02538

Reg. Diat. No. 84

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Edgemere  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Edgemere  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 106 Oak Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lydia J. Roberts

## 3. (b) Social Security Number

4. Sex Female 5. Color of race Col 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife James Roberts  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) June 2<sup>nd</sup> 1875  
 8. AGE: Years 72 Months 9 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name Patrick Scott Carter  
 13. Birthplace Virginia  
 14. Maiden name Lydia Carter  
 15. Birthplace Virginia

16. Informant Catharine Lee  
 Address 2312 Rutledge Edgemere  
 17. Removal Date thereof March 21<sup>st</sup> 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
 Location Burial Edward Co. Va.  
 18. Funeral director Mr. F. O. Edwards  
 Address 1129 N. Carroll St.  
 19. 5/23 1948  
 (Date held by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21<sup>st</sup> 1948 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1947 to March 21<sup>st</sup> 1948  
 and that I last saw him alive on March 20<sup>th</sup> 1948

Immediate cause of death Lobar Pneumonia DURATION 10 days

Due to Hemiplegia & Arteriosclerosis 8 mo.

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE E. H. Thomas M.D. M. D. or other  
 Address Gurnee Sta Md Date signed 3/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1576

02539

Reg. Dist. No.

38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baynesville Baltimore 14  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 wks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lesley Du Wayne Rodgers

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 27, 1948

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

5 wks

hrs.

min.

9. Birthplace

Baynesville Baltimore City  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month)

(day)

(year)

Cemetery or cremation

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Baynesville  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

8612 Oakleigh Rd. Balto 14  
(If rural, give LOCATION)

2. (a) If veteran, name war

-

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 23, 1948

at

2-A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him

alive on

194819

Immediate cause of death

Spina bifida with meningocele  
-supernumerary at birth  
-lumbar spina bifida

DURATION

2/4/48

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rollin C. Kuder MD, DME  
M. D. or other

Address

Towson Md

Date signed

3/4/48

RECEIVED

APR 5 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

562 02540

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BALTOCity or town CATONSVILLE, MD  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTOCity or town CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6 CEDARWOOD, RD.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOSEPHINE D. ROE

## 3. (b) Social Security Number

No

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife WALTER J. ROE SR.

7. Birth date of deceased (mo., day, yr.)

JUN. 7, 1866

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

81722

hrs.

min.

9. Birthplace

MD

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

EDGAR PLUMMER

13. Birthplace

MD.

MOTHER

14. Maiden name

ELIZABETH A. DAWSON

15. Birthplace

MD.

16. Informant

MR. WINFIELD D. ROE (SON)

Address

6314 MT. RIDGE

17.

(Burial, cremation, or removal, Which?)

Date thereof

4/1/48  
(month) (day) (year)

Cemetery or crematory

WOODLAWN

Location

BALTO Co, MD.

18. Funeral director

Wm. J. Tiekner & Sons

Address

BALTO, MD.

19.

(Date rec'd by registrar)

19

4/148A.W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29/48 19 48, at 10:05 P.M.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from

Dec. 2 19 45 to March 29 19 48and that I last saw him alive on March 29 19 48

Immediate cause of death

Chc. Glomerular Nephritis

DURATION

231

Due to

Hypertensive Fournier's371

Due to

Kidney

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Hypertensive Fournier's NephritisDate of op. 3-6-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William K. Gallager, MD

M. D. or other

Address Catonville 28, MD Date signed 4-30-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02541

93d

30

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

40 Winters Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 40 Winters Lane  
(If rural, give LOCATION)

2.(c) If veteran, same war

## 3. (a) FULL NAME

Laura V. Wilson Savory

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>Colored</u>	<u>Married</u>

6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 7, 1886

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>11</u>		..... hrs. .... min.

9. Birthplace Catonsville, Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Alexander Terrell13. Birthplace Md.14. Maiden name Mary Dorsey15. Birthplace Md.16. Informant Mr. Charles WilsonAddress 40 Winters Lane17. Burial Date thereof 3-24-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arbutus Mem. ParkLocation Baltimore Co., Md.18. Funeral director Mrs. Frances A. HemsleyAddress 578 W. Biddle St.19. 3/24/48 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st 1948 at 10.15 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-31st 1947 to 3-21st 1948and that I last saw him alive on 3-21st 1948

Immediate cause of death

Rt Hemiplegia  
Hypertensive Cardiac  
Disease

DURATION

10 days2.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE C. F. Maloney M.D. M. D. or otherAddress Catonsville, Md. Date signed 3/21/48

PLEASE WRITE IN INK, WITH UNFADING INK. Supply every item of information known. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02542

Reg. Dist. No.

30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years, 1 month, 11 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 4 years, 1 month, 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County   
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1311 Luzerne Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

(Ellene) Laura Ellen Schilling

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed

## 6. (b) Name of husband or wife

William Schilling

## 7. Birth date of

deceased (mo., day, yr.)

February 3, 1863

## 8. AGE:

Years

Months

Days

If less than one day

85

1

8

hrs.

min.

## 9. Birthplace

Texas

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

None

MOTHER FATHER

## 12. Name

Isaac Thompson

## 13. Birthplace

Pennsylvania

## 14. Maiden name

Sarah ?

## 15. Birthplace

Pennsylvania

## 16. Informant

Hospital records

## Address

Catonsville-28, Maryland

## 17.

(Burial, cremation, or removal, which?)

Date thereof

3/13/48  
(month) (day) (year)

## Cemetery or crematory

Mt. Carmel

## Location

Balto. Md.

## 18. Funeral director

William Cook Inc.

## Address

1217 St. Paul St.

## 19.

March 12, 48

A. W. Hedrick

Registrator

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 11

19. 48

at 4:25 a. m.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. alive on

19

## Immediate cause of death

## DURATION

## Due to

## Due to

## Other conditions

## Major findings of operations

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Manner of injury

## Injured at work

## 23. SIGNATURE

## Address

M. D. of

Date signed

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02543

Reg. Dist. No. *42*

## 1. PLACE OF DEATH:

County BaltimoreCity or town Arbutus  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Arbutus  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5544 Selma Ave.  
(If rural, give LOCATION)2.(a) If veteran, name War NO

## 3. (a) FULL NAME

Louis Schlickemaier

## 3. (b) Social Security Number

212-05-41924. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife M. Etta Schlickemaier6.(c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) July 22, 18888. AGE: Years 59 Months 7 Days 10 If less than one day  
hrs. min.9. Birthplace Baltimore Md.  
(Town, county, and state)10. Usual occupation Electrician11. Industry or business Gas & Electric Company12. Name John Schlickemaier13. Birthplace Baltimore Md.14. Maiden name Anna Buckwald15. Birthplace Baltimore, Md.16. Informant Mrs. Etta SchlickemaierAddress 5544 Selma Ave. Arbutus, Md.17. Burial Date thereof March 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park CemeteryLocation Baltimore18. Funeral director George W. LittleAddress 2700 Edmondson Ave.19. 3/5 AP A.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1948 at 4:37 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1948 to March 3 1948and that I last saw him alive on March 3 1948Immediate cause of death Myocardial infarctionExacerbation of DURATION 300Due to Chronic bronchitis 1 yr.Due to Carcinoma of 1 yr.Other conditions Prostate

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE B.B. Brumback M. D. or otherAddress Elkridge Md. Date signed 3/7/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BALTO  
 City or town ESSEX  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)

State MD County BALTO  
 City or town ESSEX  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 7100 EASTERN AVE  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

EMMA F. SCHMICK

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEM WHITE SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan. 2nd 1870

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

78 2 20 hrs. min.9. Birthplace Balto Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name John. SCHMICK.13. Birthplace GERMANY.14. Maiden name ?15. Birthplace ?16. Informant MRS. HATTIE ENDRESSAddress 7100 EASTERN AVE17. BURIAL Date thereof 3-25-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Pauls CmnLocation Urbansville Md18. Funeral director Mrs Chas A G. RohdeAddress 3327 Edmondson ave19. March 23, 1948 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 22 1948, at 4:15 P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 20 1948 to March 22 1948 and that I last saw him alive on March 22 1948

Immediate cause of death

Hypertensive Cardiovascular Disease

Due to

Other conditions

(Includes pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address 701 N. Kenwood Ave Date signed 3/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02545

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County... BALTIMORE

City or town... CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... BALTIMORE

City or town... CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)Street No... 10 DUTTON AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name War...

## 3. (a) FULL NAME

MARY K. SCHNEPFE

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife... HENRY B. SCHNEPFE

7. Birth date of deceased (mo., day, yr.)... SEPT. 13, 1861

6. (c) If alive, give age... D... years

8. AGE: Years Months Days If less than one day  
86 6 109. Birthplace... BALTIMORE MARYLAND  
(Town, county, and state)

10. Usual occupation... HOUSEWIFE

11. Industry or business... AT HOME

12. Name... ERNEST H. HORST

13. Birthplace... GERMANY

14. Maiden name... ANNA M. HEIDELBACH

15. Birthplace... GERMANY

16. Informant... MISS MATILDA L. SCHNEPFE

Address... 10 DUTTON AVE. CATONSVILLE

17. BURIAL Date thereof... 26 MAR. 48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... LOUDON PARK CEMETERY

Location... BALTIMORE MARYLAND

18. Funeral director... F.B. WIPPERT &amp; SON

Address... 1300 EUTAW PLACE... 17

19. 3-26-48 V.E. Harry  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

10:20P

20. DATE OF DEATH... MARCH 23, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 28, 1948 to March 23, 1948  
and that I last saw her alive on March 23, 1948

Immediate cause of death...

Myocardial

Due to... Pericardial Anomalous

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

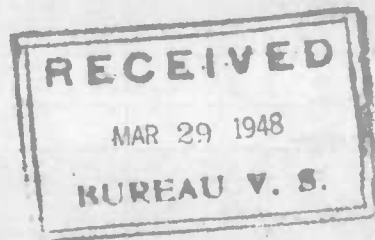
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Wm. H. ... M. D. or other

Address... 20 S. Preston St. Date signed... 3/26/48

Myocarditis.



PLEASE WRITE IN INK, WITH UNFADING INK. Supply every item of information and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02546

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2922 Windsor Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James A. Sheridan

## 3. (b) Social Security Number

YES

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Ida C. Sheridan

7. Birth date of deceased (mo., day, yr.) MARCH 31, 1869  
 6. (c) If alive, give age 74 years

8. AGE: Years 78 Months 11 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Towson, Maryland  
(Town, county, and state)10. Usual occupation Iron worker11. Industry or business Wire Iron Company12. Name ROBERT SHERIDAN13. Birthplace MARYLAND14. Maiden name REBECCA PARKS15. Birthplace MARYLAND16. Informant MRS. IDA C. SHERIDANAddress 2922 WINDSOR AVE.17. BURIAL Date thereof 3/8/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory WOODLAWNLocation BALTO CO., MD.18. Funeral director WM. J. TIERNEY & SONSAddress BALTIMORE, MD.19. March 8, 48 A. W. Redner  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 48 at 3:50 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28 19 48 to March 5 19 48  
 and that I last saw him alive on March 5 19 48

Immediate cause of death Coronary occlusion DURATION 12 hrs.

Due to Coronary sclerosis indefiniteDue to Generalized arteriosclerosis n

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville-28, Md. Date signed 3-5-48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. H 4

## 1. PLACE OF DEATH

County Balto.  
 City or town Sparrows Point.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death (Greenbelt)  
 Hospital, institution, or street address where death occurred:  
2909 Sparrows Point Rd  
 How long in hospital or institution? 10 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto.  
 City or town Same  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Same  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

George William Shiflett.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 20/1921  
 8. AGE: Years 26 Months 7 Days 23 If less than one day hrs. 1 min. 13

9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Bernard Shiflett13. Birthplace Va14. Maiden name Mary Lewis15. Birthplace Pa16. Informant Edward Shiflett21/23 Address 2909 Sparrows Point Rd17. Burial Date thereof 3-16-48  
(Burial, cremation, or removal (Which?) (month) (day) (year))Cemetery or crematorium Charlottesville Bur.Location Charlottesville, Va.18. Funeral director Edward ShiflettAddress 108 W. North Ave

19. March 12 19 48 John J. Connelley  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 12 1948 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
 and that I last saw him alive on 19

Immediate cause of death

Gunsight wound left  
lower jaw into skull  
fracture base skull  
 Due to Same  
 Due to Same

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Same Date of 3/12/48

Where did injury occur? at home Balto. MD  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury Gunsight, 22 c. Rifle Injured at work? No

23. SIGNATURE Dr. W. D. Connelley M.D. or other

Address Balto. Co. Annapolis 24th St Date signed 3/12/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02548

Reg. Dist. No. 2

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since February 10, 1948  
 Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.  
 How long in hospital or institution? Since February 10, 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 787 Carroll St  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Peter Francis Siscoesky Siscoesky

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Julia Siscoesky  
 7. Birth date of deceased (mo., day, yr.) October 21, 1900 6. (c) If alive, give age 56 years  
 8. AGE: Years 47 Months 5 Days hrs. min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation Car Driver  
 11. Industry or business  
 12. Name Anton Siscoesky  
 13. Birthplace Russia  
 14. Maiden name Catherine White  
 15. Birthplace Russia

16. Informant Personal history- Hospital records  
 Address Eudowood Sanatorium, Towson 4, Md.  
 17. Burial Date thereof April 1-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Holy Redeemers Cem.  
 Location Belair Rd.  
 18. Funeral director Joseph Tarnowski Inc.  
 Address 602 Washington Rd.  
3-29-48 A.W. Hedrich  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

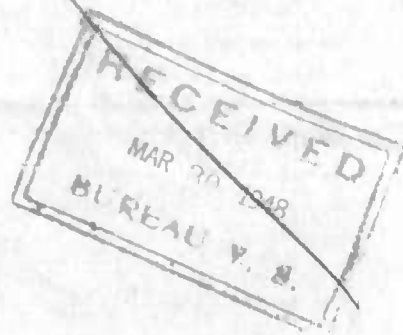
20. DATE OF DEATH March 28 1948 at 9:50 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 10, 1948 to March 28, 1948  
 and that I last saw him alive on March 28, 1948  
 Immediate cause of death

Pulmonary tuberculosis since Jan 1945  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE W.A. Bridges M. D. or other  
 Address Towson 4, Maryland Date signed 3-28-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 364 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
 How long in hospital or institution? 364 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 31 Burke Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

JOHN A. SMITH

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 7-29-93 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 54 Months 7 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Oklahoma  
 (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business \_\_\_\_\_

12. Name Adolph Smith13. Birthplace Europe14. Maiden name Elizabeth B. ?15. Birthplace Europe

16. Informant Clinical Records, Vets, Adm. Hospital  
Fort Howard, Maryland  
 Address \_\_\_\_\_

17. Burial Date thereof Mar. 30, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cemetery  
Baltimore, Maryland  
 Location \_\_\_\_\_

18. Funeral director John Ullrich  
Baltimore, Md.  
 Address \_\_\_\_\_

19. 3/30 18. 40 A.W. Hedrick  
 (Date rec'd by registrar) (Age) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 19 48 at 2:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29, 19 47 to March 27, 19 48  
 and that I last saw him alive on March 27, 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 1 Hr.

Due to Hypertensive cardio-vascular disease 10 Yrs.

Due to \_\_\_\_\_

Other conditions Left hemiplegia, old due to (1)

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A.W. St. Clair  
A.W. ST. CLAIR, M. D. M. D. or other  
 Address V.A.H. FORT HOWARD, MD. Date signed 3-27-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02550

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Reisterstown Route 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 33 years  
 Hospital, institution, or street address where death occurred:  
Nicodemus Road Reisterstown  
 How long in hospital or institution?..... -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore  
 City or town..... Reisterstown Route 2  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Nicodemus Rd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... No

## 3. (a) FULL NAME

Sarah Elizabeth Stambaugh

## 3. (b) Social Security Number

None

4. Sex..... F 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... S  
 6. (b) Name of husband or wife..... -  
 7. Birth date of deceased (mo., day, yr.)..... March 9 1866  
 8. AGE: Years..... 82 Months..... 0 Days..... 6 If less than one day..... hrs. .... min.

9. Birthplace..... Woodensburg Balto Co Md  
 (Town, county, and state)  
 10. Usual occupation..... Household duties  
 11. Industry or business..... -

FATHER 12. Name..... Harry Stambaugh  
 13. Birthplace..... York Pa  
 MOTHER 14. Maiden name..... Mary Ebaugh  
 15. Birthplace..... Dover Balto Co Md

16. Informant..... Mrs J C Dietrich  
 Address..... 2910 Harford Ave Balto Md

17. Burial..... Burial Date thereof..... Mar 17 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Druid Ridge Cemetery  
 Location..... Pikesville Md

18. Funeral director..... Wm Berryman & Sons  
 Address..... Reisterstown Md

19. 3-16- 19 48 Mary B. E Line  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 15 19 48 at 1 P.M. short

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-15 19 48, to 3-15 19 48  
 and that I last saw him alive on Just seen alive 19 48

Immediate cause of death..... Anterior choroidal C.V. disease DURATION..... 5 yrs - 10

Due to.....

Due to.....

Other conditions..... Arteriosclerosis 10 yrs - 10  
 (Include pregnancy within 3 months of death)

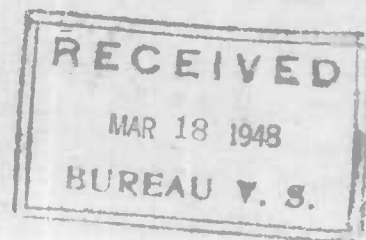
Major findings of operations..... None Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... Dr. J. D. Eagles M.D. Exam.  
 M. D. or other  
 Address..... Reisterstown Md. Date signed..... 3-16-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

02551

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 800 W. Baltimore Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Frank Stapp FRANK STAPP

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Josephine Shaw  
7. Birth date of deceased (mo., day, yr.) September 9, 1878  
6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 69 Months 6 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation PAPER HANGER  
11. Industry or business OWN BUSINESS  
12. Name Unknown Louis Stapp  
13. Birthplace Unknown Annapolis Maryland  
14. Maiden name Unknown Emma Clifford  
15. Birthplace Unknown Annapolis Maryland

16. Informant Hospital Records  
Address Catonsville-28, Maryland  
17. Burial Date thereof 23 March '48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Loudon Park Cemetery  
Location Baltimore Maryland  
F.B. WIPPERT & SON  
18. Funeral director  
Address 1300 EUTAW PLACE ...17

19. 3-22-48 A. W. Hedrick  
(Date rec'd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 48 at 8:55 a.m.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 16 19 48 to March 20 19 48  
and that I last saw him alive on March 20 19 48  
Immediate cause of death  
Bronchopneumonia DURATION 4 days  
Due to Hypertensive cardiovascular disease indef.  
Due to Arteriosclerosis indef.  
Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results not done  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury Isadore Tuerk Injured at work? \_\_\_\_\_  
23. SIGNATURE Isadore Tuerk, MD. M. D. or other \_\_\_\_\_  
Address Catonsville-28, Md. Date signed 3-20-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02552

93d

Reg. Dist. No.

785-43

## 1. PLACE OF DEATH:

County BaltimoreCity or town 6519 Golden Ring Road  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6519 Golden Ring Road  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Marion Jeremiah Stone

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Hannah Dye Stone (wid)

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 18628. AGE: Years 85 Months 2 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Port Deposit, Md.  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Joseph J. Stone13. Birthplace N.Y.14. Maiden name Mary Ellen O'Bryan15. Birthplace New Orleans16. Informant Fannie Ketcher (daughter)Address 6519 Golden Ring Road Balto. 6 Md.17. Burial Date thereof 3/28/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Harlem de Vigor18. Funeral director Burroughs & SonAddress Harlem de Vigor19. Mar. 27 19 48 G. L. Lewis M. D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 48, at 12:30 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 48 to March 26 19 48and that I last saw him alive on March 26 19 48Immediate cause of death CoronaryThrombosis DURATION 12 hrsDue to arterio-scleroticcardio-vascular disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. M. Burroughs M. D. or otherAddress Balto 6 Md Date signed 3-26-48

RECEIVED

MAR 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02553

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Ellicott City Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles B. Streaker

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widower8. (b) Name of husband or wife... Sarah Walker Streaker

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

July 21, 1877

8. AGE:

Years

Months

Days

If less than one day

70717

hrs.

min.

9. Birthplace... Alborton, Md.  
(Town, county, and state)10. Usual occupation... Farmer

11. Industry or business

FATHER  
MOTHER12. Name... John W. Streaker

13. Birthplace

Md14. Maiden name... Julia A. Gosnell

15. Birthplace

Md16. Informant... Mrs. David KalbAddress... Ellicott City, Md.17. Burial  
(Burial, cremation, or removal. Which?)

Date thereof...

3-11-48

(month) (day) (year)

Cemetery or crematory... Good ShepherdLocation... Ellicott City, Md.18. Funeral director... F.C. HiginbothamAddress... Ellicott City, Md.19. March 11, 1948  
(Date rec'd by registrar)W.E. Harry

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... BaltimoreCity or town... Ellicott City Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Johnny Cake Road  
(If rural, give LOCATION)

2. (a) If veteran, name war...

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 8 19. 48 at 10:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 6 19. 48 to March 8 19. 48and that I last saw him alive on March 8 19. 48

Immediate cause of death

Heart failure fromSenileDue to Heart failureof senileDue to I did not see himuntil 2 days beforeOther conditions... death. He hadnot complained.  
(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... A. C. Smith M. D. or otherAddress... 4309 Federal Hwy Date signed... March 9

RECEIVED

MAR 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02554 48

## 1. PLACE OF DEATH

County Balto.City or town Mobile River  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D. 14, Box 375, Harwood Park

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto.City or town Balto - 20  
(If outside city or town limits, write RURAL and give nearest town)Street No. HARWOOD PARK  
(If rural, give LOCATION) MD2.(a) If veteran, name war No

## 3. (a) FULL NAME

Nina Alma Streb.

## 3. (b) Social Security Number

N.

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

George L. Streb.

## 7. Birth date of deceased (mo., day, yr.)

Aug 11 / 1882

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

66630

hrs.

min.

## 9. Birthplace

Baltimore Md.  
(Town, county, and state)

## 10. Usual occupation

At home

## 11. Industry or business

Harry C. Morris

## MOTHER

## FATHER

## 12. Name

Harry C. Morris

## 13. Birthplace

Baltimore, Md.

## 14. Maiden name

Mary Rose

## 15. Birthplace

Baltimore, Md

## 16. Informant

MR. ADELE A. HILL

## Address

3425 REDMONT AVE

## 17.

BURIAL  
(Burial, cremation, or removal. Which?)

## Date thereof

3/12/48  
(month) (day) (year)

## Cemetery or crematory

WOODLAWN

## Location

BALTO Co. MD

## 18. Funeral director

Wm J. TICTON & Sons, INC

## Address

Baltimore MD

## 19.

3-12-48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Mar 10 1948 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

## Immediate cause of death

Coronary occlusion

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## 23. SIGNATURE

Dr. Morris  
Address Balto Co. Maryland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02555

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Ft. Howard  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Ft. Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Todd & Bayside Aves.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

May Estelle Sturgis

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Benjamin R.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1883

8. AGE: Years 64 Months 8 Days 21 If less than one day  
 ..... hrs. .... min.

9. Birthplace Baltimore Md.  
(Town, county, and state)10. Usual occupation house wife

11. Industry or business

FATHER 12. Name Hall Tyson  
 13. Birthplace Baltimore Md.

MOTHER 14. Maiden name Lillian Ganant  
 15. Birthplace Baltimore Md.

16. Informant HusbandAddress Todd & Bayside Aves.

17. Burial Date thereof 3/27/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BaltimoreLocation North Ave & Rose St.18. Funeral director Clarence F. HoffmannAddress 1639 Broadway.

19. Mar 25 - 48 Dawson L. Harber  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948 at 11 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 16 1948 to March 24 1948  
 and that I last saw her alive on March 23 - 1948

Immediate cause of death Cerebral Embolus DURATION onset

Due to Chronic myocardial deg. 3 yrs

Due to Generalized arteriosclerosis?

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

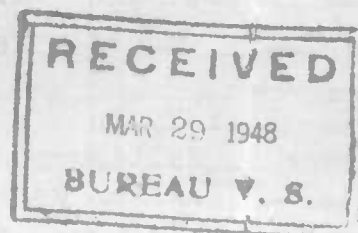
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dawson L. Harber M. D. or other

Address Sperry Point, Md. Date signed 7/25/48

Dr. Farber  
914 D. H.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02556

170C

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County Belts Co.City or town Perry Hall  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 1/2 yrs.Hospital, institution, or street address where death occurred:  
Belair Rd.

How long in hospital or institution?

## 3. (a) FULL NAME

MartinSutte

(Sutte)

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 15th, 1881

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

66919

hrs.

min.

9. Birthplace Latvia

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name Arthur M. Sutte13. Birthplace Unknown

MOTHER

14. Maiden name Anna Strauss15. Birthplace Unknown16. Informant Mrs. Anna ZemelAddress Pipersville, Pa.17. burial  
(Burial, cremation, or removal. Which?)Date thereof Mar. 8, 1948

(month) (day) (year)

Cemetery or crematory Durham Luth. CemeteryLocation Durham, Pa.18. Funeral director Larsen Funeral HomeAddress 7401 Belair Road19. 3/5/48 19  
(Date recd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BeltsCity or town Perry Hall Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Belair Rd.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 48 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death

Fractured neck; crushed chest  
right; compound fractures to the legs

DURATION

3/4/48Sudden

Due to

Accident - struck by auto3/4/48

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, in the following:

Accident 3/4/48  
Accident, suicide, or homicideWhere did injury occur? Perry Hall Belts Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public highway - Belair  
Rd.Means of injury Struck by auto Injured at work? No

23. SIGNATURE

Rolling B. Hudson M.D. D.M.E.  
Address Towson Md. Date signed 3/4/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02557

95C

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
How long in hospital or institution? 6 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 310 West End  
(If rural, give LOCATION)  
2(a) If veteran, name war WW-II

### 3. (a) FULL NAME

HARLEY A. TALL

### 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Sylvia Tall  
7. Birth date of deceased (mo., day, yr.) Jan. 25, 1901 8. (c) If alive, give age 27 years  
8. AGE: Years 47 Months 2 Days 5 If less than one day  
hrs. min.

9. Birthplace Toddville, Maryland  
(Town, county, and state)  
10. Usual occupation Truck Driver  
11. Industry or business

12. Name Leander Tall  
13. Birthplace Maryland  
14. Maiden name Emma Pritchett  
15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Maryland

17. Removal Date thereof 3-30-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Le Compte Funeral Home  
Location Cambridge, Md.  
Howard N. Blight, Jr.

18. Funeral director Howard N. Blight, Jr.  
Address 4914 Belair Rd., Balto., Md.

19. March 30, 1948 John S. Cornille  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 30, 1948 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21, 1948 to March 30, 1948  
and that I last saw him alive on March 30, 1948

Immediate cause of death Cardiac decompensation DURATION 3 Yrs.

Due to Coronary sclerosis 3 Yrs.

Due to

Other conditions Pulmonary Infarction, left 10 days  
Cardiac dilatation 2 wks.  
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results No Autopsy  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Scott  
R. J. SCOTT, M. D. M. D. or other  
V.A.H. FT. HOWARD, MD. Address Date signed 3-30-48

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 8 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Balts

City or town Ridge wood  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balts

City or town Ridge wood  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1409 Hegheven Ave  
(If rural, give LOCATION)

2(a) If veteran, name war .....

### 3. (a) FULL NAME

Amelia Taylor

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife William Taylor

7. Birth date of deceased (mo., day, yr.) Feb 7 1862 6. (c) If alive, give age ..... years

8. AGE: Years 86 Months - Days 22 If less than one day ..... hrs. .... min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Cat. home

11. Industry or business .....

12. Name Don't Know

13. Birthplace .....

14. Maiden name Don't Know

15. Birthplace .....

18. Informant John J. Taylor

Address 1409 Hegheven Ave

17. Burial Date thereof Feb. 4/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location A A Co Inc

18. Funeral director William Taylor Home

Address 2008 Orleans St

19. 3/3 48 A.W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1 19 48 at 2 35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 48 to March 1 19 48

and that I last saw him alive on March 1 19 48

Immediate cause of death Acute myocardial failure DURATION 1 day

Due to Hypertension arteriosclerotic  
Cardio-Vascular disease

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John F. Coalahan M. D. or other

Address 4209 Wilkes St Date signed 3/2/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore</u> City or town..... <u>Howardville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? ..... Hospital, institution, or street address where death occurred: <u>8 Walnut Ave.</u> How long in hospital or institution? .....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Md.</u> County..... <u>Baltimore</u> City or town..... <u>Howardville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>8 Walnut Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Joseph Samuel Taylor</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>Colored</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widower</u>		<b>MEDICAL CERTIFICATION</b> <span style="float: right;">P</span>	
<b>6. (b) Name of husband or wife</b> .....				<b>2D. DATE OF DEATH</b> <u>March 31,</u> 19 <u>48</u> at <u>11:45</u> M.			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>April 13, 1864</u>				<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Jan.</u> 19 <u>46</u> , to <u>3-31</u> 19 <u>48</u> and that I last saw him alive on <u>3-29-</u> 19 <u>48</u>			
<b>8. AGE:</b> Years <u>83</u> Months <u>11</u> Days <u>18</u> If less than one day ..... hrs. .... min.		<b>6. (c) If alive, give age</b> ..... years		<b>Immediate cause of death</b> .....		<b>DURATION</b> .....	
<b>9. Birthplace</b> <u>Valley Lee, St. Marys Co., Md.</u> (Town, county, and state)				<u>Acute Cor. Pulm. Infarct</u> <u>Myocarditis</u> <u>Arteriosclerosis</u>			
<b>10. Usual occupation</b> ..... <u>Retired</u>				<b>Due to</b> .....			
<b>11. Industry or business</b> .....				<b>Due to</b> .....			
<b>12. Name</b> ..... <u>Peter Taylor</u>				<b>Other conditions</b> .....			
<b>13. Birthplace</b> ..... <u>Md.</u>				(Include pregnancy within 3 months of death)			
<b>14. Maiden name</b> ..... <u>Ellen Robinson</u>				<b>Major findings of operations</b> .....			
<b>15. Birthplace</b> ..... <u>Md.</u>				Date of op. ....			
<b>16. Informant</b> ..... <u>Mr. Leroy Taylor</u>				<b>Autopsy results</b> .....			
Address <u>2010 Druid Hill Ave.</u>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>Burial</b> Date thereof <u>4-4-48</u> (Burial, cremation, or removal. Which?) (month) (day) (year)				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>			
Cemetery or crematory..... <u>St. Thomas' Cemetery</u>				Accident, suicide, or homicide..... Date of .....			
Location..... <u>Baltimore Co., Md. (Randallstown)</u>				Where did injury occur? ..... (City or town) (County) (State)			
<b>18. Funeral director</b> ..... <u>Mrs. Frances A. Hemsley</u>				Injured at home, farm, industry, public place (where?) .....			
Address <u>578 W. Biddle St.</u>				Means of injury..... Injured at work?.....			
<b>19.</b> <u>4/2</u> 19 <u>48</u> <u>A.W. Hedrick</u> (Date rec'd by registrar) Registrar				<b>23. SIGNATURE</b> <u>W. J. Butler, Jr.</u> M. D. or other Address <u>2033 Euclid Ave.</u> Date signed <u>4/1/48</u>			

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

### 1. PLACE OF DEATH:

County Baltimore

City or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Robert Thompson, Sr.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 422 F. Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

216-09-5727

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Irene Manning Thompson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 8, 1885

8. AGE: Years 63 Months 1 Days 14 If less than one day  
.....hrs. ....min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Crane Operator

11. Industry or business Bethlehem Steel

12. Name William Thompson

13. Birthplace Scotland

14. Maiden name Unknown

15. Birthplace II

16. Informant Thomas Thompson - son

Address 422 F. St., Sparrows Point, Md.

17. Burial 3/25/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory XXX Oak Lawn

Location 7225 Eastern Ave., Baltimore, Md.

18. Funeral director Schimunek Funeral Home, Inc.

Address 2601-3-5 E. Madison Street

19. 3-20 19 48 A. W. Helms  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 22 March 19 48 at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Feb 19 48, to 22 March 19 48

and that I last saw him alive on 22 March 19 48

Immediate cause of death Cardiac Failure

DURATION

Due to Heart disease 2 yrs

Due to

Other conditions Left hemiplegia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Herbert Morrison M. D. or other

Address 2534 Yorkway Date signed 22 Mar. 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02561

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 yrs. 6 mos. 1 day

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 9 yrs. 6 mos. 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Towson 4  
(If outside city or town limits, write RURAL and give nearest town)Street No. Satyr Hill Road R.F.D. 6  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

TICE, George

## 3. (b) Social Security Number

4. Sex 5. Color or race B.(a) Single, married, widowed, or divorced

MaleWhiteMarried6.(b) Name of husband or wife Ada Tice7. Birth date of deceased (mo., day, yr.) May 27, 1879 6.(c) If alive, give age 67 years8. AGE: Years Months Days If less than one day  
68 9 4 hrs. min.9. Birthplace Pennsylvania?  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming.12. Name George W. Tice13. Birthplace Pennsylvania?14. Maiden name Catherine Miller15. Birthplace Unk.16. Informant Hospital recordsAddress Catonsville-28, Maryland17. Burial Date thereof 3/5/48  
(Burial, cremation, or removal, Which?) (Month) (day) (year)Cemetery or crematorium Family LotLocality Mc Connellsburg Pa18. Funeral director Edw J MayhewAddress Catonsville MD19. March 3 19 48 V E. Harry

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 48 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 30 19 38 to March 2 19 48and that I last saw him alive on March 2 19 48Immediate cause of death Hemorrhage of bowels and bladder DURATION 48 hrs.Old left hemiplegia 1 mo.Due to Cerebral hemorrhage, old. indef.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Isadore Tuerk, M. D. M. D. or otherAddress Catonsville-28, Maryland Date signed 3-2-48

RECEIVED

MAR 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02562

XX

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 147 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 147 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1811 Aisquith St.

(If rural, give LOCATION)

2.(a) If veteran, name war

WW I

## 3. (a) FULL NAME

RALPH C. TIMANUS

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lillian Timanus6. (c) If alive, give age 51 years

## 7. Birth date of

deceased (mo., day, yr.) February 20, 1895

## 8. AGE:

Years

Months

Days

If less than one day

53025

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Machinist

## 11. Industry or business

## FATHER

12. Name William Timanus13. Birthplace Maryland

## MOTHER

14. Maiden name Clara Martin15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hesp.Address Fort Howard, Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 18, 1948

(month) (day) (year)

Cemetery or crematory Louden Park CemeteryLocation Frederick Rd., Baltimore, Md.18. Funeral director Witzke Funeral DirectorsAddress 4101 Edmondson Ave., Balto., Md.

19. (Date rec'd by registrar)

19

3/18

19

48xxDr

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 19 48 at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 20 19 47 to March 15 19 48and that I last saw him alive on March 15 19 48Immediate cause of death ADENOCARCINOMA OF LIVER

DURATION

6 mos.Plus

Due to

Due to

Other conditions Multiple Polyposis of Colon Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Richard Land M.D.

M. D. or other

Address V.A.H. Ft. Howard, Md.Date signed 3-15-48

1942  
1941  
1940  
1939

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Victory Villa  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County BG  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 16 Slipstream Court  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 2. (a) FULL NAME

Lma Lee Toula

## 3. (b) Social Security Number

4. Sex F 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1947 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months 3 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Wilson R. Toula  
 13. Birthplace Baltimore  
 14. Maiden name Josephine Hubbard  
 15. Birthplace Baltimore

16. Informant Wilson R. Toula  
 Address 16 Slipstream Ct. Victory Villa

17. Burial Date thereof 3-19-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill

Location Baltimore

18. Funeral director Frank Brachason  
 Address 900 N. Chester St.

19. 3/19 1948 R.W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 1948 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Suffocation  
Larynx spasm -  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

DURATION

?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 3/18/48

Accident, suicide, or homicide Accident Date of \_\_\_\_\_

Where did injury occur? Victory Villa - Baltimore, Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Strangled in vomitus Injured at work? No.

23. SIGNATURE

Dr. J. H. Starn Bay View, Md.  
 Address Bay View, Md. Date signed 3/18/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

1952 not p.c. 02563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

02564

34

## 1. PLACE OF DEATH

County BaltimoreCity or town Upper Falls (Rural)  
(outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Richard W. P. Tracey

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

m

6. (b) Name of husband or wife

Blanch J. Sullivan

7. Birth date of

deceased (mo., day, yr.)

Oct 9 - 18656. (c) If alive, give age 78 years

8. AGE:

Years

Months

Days

It less than one day

82427

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Richard E. Tracey

13. Birthplace

Maryland

14. Maiden name

Mary A. Price

15. Birthplace

Maryland

16. Informant

Mrs R. P. Tracey

Address

Upper Falls Md

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Mar 9/1948

Cemetery or crematory

Grace Methodist

Location

Balts Co - Md.

18. Funeral director

Edw. A. Hipton

Address

Hampstead Md

19.

(Date rec'd by registrar)

Mar 4 1948

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Balto

City or town

Upper Falls - (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 6 1948

19.

at 11:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1943 to March 6 1948

and that I last saw him alive on

March 3 1948

Immediate cause of death

Carcinoma of Prostate

DURATION

1 yr.

Due to

Due to

Other conditions

Carcinoma of Prostate

(Include pregnancy within 8 months of death)

Major findings of operations

Ca of Prostate

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Marion C. Porterfield

M. D. or other

Address

Hampstead Md

Date signed

3-6-48

RECEIVED

MAR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

02566

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Monkton C.O. (Heeford)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Lifetime  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore  
 City or town..... Monkton (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... York Rd. - Heeford  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... No

## 3. (a) FULL NAME

Jacob Montgomery Vance

## 3. (b) Social Security Number

none

## 4. Sex

M

## 5. Color of race

W

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Katherine E. (nee Nicoll)

## 7. Birth date of deceased (mo., day, yr.)

Nov. 2, 1872

## 8. (c) If alive, give age

73 years

## 8. AGE:

Years

Months

Days

If less than one day

75523

hrs.

min.

## 9. Birthplace

Balta. Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Livery Stable operator

## 11. Industry or business

retired 15 years

## FATHER

## 12. Name

Howard Vance

## MOTHER

## 13. Birthplace

Balta. Co. Md.

## 14. Maiden name

Ella Rayston

## 15. Birthplace

Balta. Co. Md.

## 16. Informant

Mrs. J. M. Vance

## Address

Monkton Md.

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Mar. 27, 1948  
(month) (day) (year)

## Cemetery or crematory

Heeford Baptist Cem.

## Location

Heeford, Balto. Co., Md.

## 18. Funeral director

Landrum M. Brooks

## Address

Sparks, Md.

## 19.

Mar. 28  
(Date rec'd by registrar)48 Mrs. Howard S. Markline  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Mar. 25 - 1948 at 2 A. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/15 - 1948 to 3/24 - 1948

## and that I last saw him alive on

3/24 - 1948

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

11 hrs.

## Due to

Arteriosclerosis

## Due to

(Second attack)

## Other conditions

4 yrs.

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

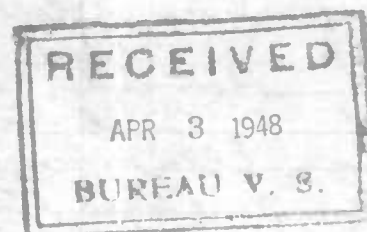
Injured at work?

## 23. SIGNATURE

Walter C. Evans M.D.  
M. D. or other

Address

Cockeysville Md.Date signed 3/28/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02567

93d

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 yrs  
 Hospital, institution, or street address where death occurred:  
3559 Selma ave  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Baltimore  
 City or town Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3559 Selma ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

William Thomas Vansant

## 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Mrs. Thorne Vansant

7. Birth date of deceased (mo., day, yr.) March 6 1869 6. (c) If alive, give age 74 years

8. AGE: Years 79 Months 0 Days 8 If less than one day - hrs. - min.

9. Birthplace Stiefford Md  
 (Town, county, and state)

10. Usual occupation Payroll master11. Industry or business Retired (Pa. R.R.)12. Name John B. Vansant13. Birthplace Md.14. Maiden name Sarah F. ?15. Birthplace Md.16. Informant Mrs. Sarah F. VansantAddress 3559 Selma ave Halethorpe17. Burial Burial Date thereof 3/17/48

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory RiverviewLocation Wilmington Del.18. Funeral director William Cook Inc.Address 1217 St. Paul St.19. 3/16 18 W. Hedrick

(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1948 at 11:15 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to March 14 1948and that I last saw him alive on March 14 1948Immediate cause of death MyocardialinfarctionDue to CoronaryarteriosclerosisDue to General arterio-sclerosisOther conditions HypertensionObesity

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Brumby M. P. or otherAddress Elkridge Md Date signed 3/17/48

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

02568

## 1. PLACE OF DEATH

County BaltimoreVillage or City InvernessRegistration Dist. No. 44

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

Leon Adam Wancowicz

(a) Residence: No.

69 Wise Ave

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)married

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofMarie Szabelska

6. DATE OF BIRTH (month, day, and year)

Jan 7, 1913

7. AGE

Years

Months

Days

If LESS than  
1 day, hrs.  
or min.35210

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.Laborer10. Data deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation

12. BIRTHPLACE (city or town)

(State or country)

FATHER

13. NAME

Casmir Wancowicz

14. BIRTHPLACE (city or town)

(State or country)

Poland

MOTHER

15. MAIDEN NAME

Pauline ?

16. BIRTHPLACE (city or town)

(State or country)

Poland

17. INFORMANT

(Address)

Mrs. Marie Szabelska  
69 Wise Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place

Holy Rosary

Data

3-20, 1948

19. UNDERTAKER

(Address)

John G. Connelly  
418 Eastern Ave. Essex, Md.

20. FILED

3-18, 1948John G. Connelly

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY, That I attended deceased from

3-151948

to

3-171948

I last saw him alive on

3-171948to have occurred on the date stated above, at 12:30 a.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Pulmonary Tuberculosis

Date of onset

3 yrs.

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

Eugene J. Nery  
1500 N. 1st St., Md.

M. D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Chronic interstitial nephritis

Cerebral hemorrhage

Date of onset

1915

1921

July 5, 1927

Other contributory causes of importance:

Gallstones

May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Run over by street car

Peritonitis

Date of onset

1 week ago

1 week ago

3 days ago

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02569

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 1 mo., 4 days.  
 Hospital, institution, or street address where death occurred: Mt. Wilson  
Branch, Md. T. B. Sanatorium  
 How long in hospital or institution? 0 yrs., 1 mo., 4 days.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County.....  
 City or town..... Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3504 Fairview Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Dr. Frederick C. Warring, Sr.

## 3. (b) Social Security Number

705-10-4544

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Blanche R. Warring  
 6. (c) If alive, give age 64 years  
 7. Birth date of deceased (mo., day, yr.) September 1, 1884  
 8. AGE: Years 63 Months 6 Days 3 If less than one day  
 hrs. min.

9. Birthplace Middletown, New York  
 (Town, county, and state)  
 10. Usual occupation Surgeon  
 11. Industry or business

FATHER  
 12. Name Lewis S. Warring  
 13. Birthplace Monticello, New York  
 MOTHER  
 14. Maiden name Amzenia Hazen  
 15. Birthplace Massachusetts

16. Informant Dr. Frederick C. Warring, Sr.  
 Address 3504 Fairview Ave., Balto., Md.  
 17. Cremation Date thereof Mar. 6, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Greenmount Cemetery Balto.  
 Location Greenmount Ave. & Oliver St. Md.

18. Funeral director Tickner & Sons  
 Address North & Pa. Ave., Baltimore, Md.  
 19. Mar. 4, 1948 Earl T. Webster  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1948 at 12:00 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan. 29, 1948 to Mar. 4, 1948  
 and that I last saw him alive on March 4, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 3 mos.

Due to Tubercle Bacilli

Due to

Other conditions Senile Dementia

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M.D. or other  
 Address Mount Wilson, Md. Date signed 3/4/48

**RECEIVED**

MAR 9 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02570

Reg. Dist. No. 38

1. PLACE OF DEATH: Baltimore  
County Towson  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
514 Virginia Avenue  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 514 Virginia Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME MARY JANE WATSON

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 22, 1871 6. (c) If alive, give age years

8. AGE: Years 76 Months 4 Days 21 If less than one day hrs. min.

9. Birthplace Baltimore Co. Maryland  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Balto. Co. Public School Teacher

12. Name John C. Watson

13. Birthplace Ireland

14. Maiden name Elizabeth Bothwell

15. Birthplace England

16. Informant Wilson W. Watson, Jr.

Address 514 Virginia Ave., Towson, Md.

17. Burial Date thereof Mar. 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Prospect Hill Cemetery

Location Towson, Md.

16. Funeral director John Burns' Sons

Address Towson, Maryland

19. March 15, 1948 Registrar John C. Watson

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1948 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1948 to March 12, 1948

and that I last saw him alive on March 12, 1948

Immediate cause of death Pneumonia (Bacter)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Wilson W. Watson M. D. or other

Address Towson, Md. Date signed 3/15/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The subject age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

02571

93d

44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Edgemere

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2515 S. Dryden Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Edgemere

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2515 S. Dryden Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ida Eva Welker

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife William E. Welker

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9, 18818. AGE: Years 67 Months 1 Days 26 If less than one day hrs. min.9. Birthplace Pennsylvania  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Perigal Campbell13. Birthplace Unknown14. Maiden name Lidia Herb15. Birthplace Unknown16. Informant Raymond WelkerAddress 3465 Baybriar Road, Dundalk17. Removal Removal Date thereof March 10, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Fair View CemeteryLocation Williamstown, Pennsylvania18. Funeral director Roland L. FisherAddress 2112 Dundalk Ave.19. Mar 8 19 48 Davon L. Harbor  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 48 at 7:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 19 48 to March 6 19 48 and that I last saw him alive on March 4 19 48Immediate cause of death Cerebral Hemorrhage DURATION 5 daysDue to Hypertensive Cardiovascular disease 10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Farber, M.D. M. D. or otherAddress Spanous Point, Md Date signed 3-8-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02572

Reg. Dist. No. 9 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since Nov. 6, 1945

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since Nov. 6, 1945

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County noneCity or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1822 E. Baltimore ST.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

FRANK H. WHITE.

## 3. (b) Social Security Number

217-05-4191

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Helen White

7. Birth date of

deceased (mo., day, yr.)

Dec 22, 1907

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

403

hrs.

min.

9. Birthplace

Bertie Co., No. Carolina  
(Town, county, and state)

10. Usual occupation

Crane Operator

11. Industry or business

Both Steel Company and  
Wheat Grower

FATHER

12. Name

Frank White

13. Birthplace

North Carolina

MOTHER

14. Maiden name

Madie M. Hoard

15. Birthplace

North Carolina

16. Informant

Personal history-Hospital recordsAddress Eudowood Sanatorium, Towson 4, Md.

17.

Buried  
(Burial, cremation, or removal. Which?)

Date thereof

3/27/48  
(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Eastern Ave. Rd.

18. Funeral director

John B. Connolly

Address

418 Eastern Ave.

19.

3/24/48  
(Date rec'd by registrar)

19

John B. Connolly  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1948 at 4:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6 1945 to March 24 1948and that I last saw him alive on March 23 1948

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

DURATION

Since  
May  
1942

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. A. Bridges

M. D.

Address Towson 4, Md.Date signed 3-24-48

RECEIVED

APR 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02573

Reg. Dist. No. XX

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 932 W. Fayette St.  
(If rural, give LOCATION)2(a) If veteran, name war WW I

## 3. (a) FULL NAME

BENJAMIN T. WICKS

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Separated6. (b) Name of husband or wife Lillian Wicks6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) 8-24-92

8. AGE: Years Months Days If less than one day

5575hrs.min.9. Birthplace Anne Arundel Co., Md.  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name William Wicks13. Birthplace MarylandMOTHER 14. Maiden name Rachel Taylor15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. HospitalAddress Fort Howard, Maryland17. Burial Date thereof 4-2-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryBaltimore, Maryland

Location

18. Funeral director Charles R. LawAddress 802 Madison Ave., Balto., Md.19. 3/31 19 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 48 at 5:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 22 19 48 to March 29 19 48and that I last saw him alive on March 29 19 48

Immediate cause of death

Sarcoma of left ankle, metastatic to left jaw, lungs & lymph nodes

DURATION

6 Mos.Due to plus

Due to

Other conditions Aspiration Pneumonia & lung abscess

(Include pregnancy within 3 months of death)

Unknown

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. MANAUGH, M. D. Chief Professional ServiceAddress VAH Ft. Howard, Md. Date signed 3-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02574

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County BaltimoreCity or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

52 Bond Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 52 Bond Avenue

(If rural, give LOCATION)

2.(c) If veteran, name war

## 3. (a) FULL NAME

Clara G. Williams

## 3. (b) Social Security Number

4. Sex F. 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Rev. Matthais Williams

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) November 24, 18798. AGE: Years 68 Months 3 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Howard Co., Maryland  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John Garrett13. Birthplace Md.14. Maiden name Anna Hall15. Birthplace Md.16. Informant Rev. Matthais WilliamsAddress 52 Bond Ave. Reisterstown, Md.17. Burial March 9, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory West Liberty M. Chr. Cem.Location West Liberty, Howard Co., Md.18. Funeral director Mrs. Frances A. HemsleyAddress 578 W. Biddle St.19. March 9, 1948 A. W. Hedrick  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 48 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-16 19 46, to 3-7 19 48and that I last saw him/her alive on 3-6 19 48

Immediate cause of death

arteriosclerotic & V. Disease DURATION 3 yrsHypertensive & V. Disease 2 yrsGastritis 3 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings at operations \_\_\_\_\_

NONE Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accidental, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? NONE

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE D. D. Caples M. D. or otherAddress Reisterstown, Md. Date signed 3-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02575

Reg. Diat. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years, 9 months, 5 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 4 years, 9 months, 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Catonsville-28  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 644 Orpington Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Marie Wissman

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Ludwig Wissman  
 7. Birth date of deceased (mo., day, yr.) August 17, 1901  
 8. AGE: Years 46 Months 6 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 8.(c) If alive, give age \_\_\_\_\_ years

9. Birthplace Rodenbergen, Germany  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home

**FATHER**  
 12. Name Conrad Protzman  
 13. Birthplace Germany  
**MOTHER**  
 14. Maiden name Johanna Reutzel  
 15. Birthplace Germany

16. Informant Hospital records  
 Address Catonsville-28, Maryland

17. Burial Date thereof 3-6-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Moreland Memorial Park  
 Location Baltimore, Maryland  
 18. Funeral director Leonard J. Ruck

Address 5305 Harford Road, 14

19. 3/6 48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 48 at 10:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 19 43, to March 4 19 48  
 and that I last saw him or alive on March 4 19 48

Immediate cause of death Carcinoma of the cervix with metastasis DURATION indefinite

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations Radium implantation  
Results: cessation of bleeding. 12-16-47 and 1-22-48  
 Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Isadore Turk, M.D. M. D. or other  
Catonsville-28, Md. Address..... Date signed 3-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02576

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 days  
 Hospital, institution, or street address where death occurred:  
Veterans Administration Hosp., Ft. Howard, Md.  
 How long in hospital or institution? 25 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 817 Greenmount Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... WW I

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Negro 6. (a) Single, married, widowed, or divorced..... Widower  
 6. (b) Name of husband or wife..... Widower  
 7. Birth date of deceased (mo., day, yr.) May, 1896 8. (c) If alive, give age..... years  
 8. AGE: Years..... 51 Months..... 10 Days..... ? If less than one day..... hrs. .... min.

9. Birthplace..... Gaffney, South Carolina  
 (Town, county, and state)  
 10. Usual occupation..... Unemployed  
 11. Industry or business.....  
 12. Name..... Elis Wood  
 13. Birthplace..... South Carolina  
 14. Maiden name..... Bertheni Brown  
 15. Birthplace..... South Carolina

16. Informant..... Clinical Records, Vets. Adm. Hosp.  
 Address..... Fort Howard, Maryland  
 17. Burial Date thereof..... March 5, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Baltimore National Cemetery  
Baltimore, Maryland  
 Location.....  
Charles R. Law  
 18. Funeral director.....  
 Address..... 802 Madison Ave., Balto., Md.  
 19. 3/x xf H. W. Hedrick  
 (Data sent by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 1, 1948 at 12:15 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5, 1948 to March 1, 1948  
 and that I last saw him alive on March 1, 1948

Immediate cause of death.....  
Subacute Nephritis: Type  
Undetermined  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results..... Substantiated Above  
 PHYSICIAN: Please underlines the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... H. C. Managh  
H.C. MANAGH, M.D. Chief Professional Ser.  
 Address..... V.A.H. Ft. Howard, Md. Date signed 3-2-48

ms Annie MacWood

~~8a 4597~~

495-7

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02577

Reg. Dist. No. 44

1. PLACE OF DEATH:  
County Baltimore,  
City or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 21 days  
Hospital, institution, or street address where death occurred:  
VAH. Fort Howard, Md.  
How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 144 Colvin St  
(If rural, give LOCATION)  
2.(a) ☒ Veteran, name war WW II

### 3. (a) FULL NAME

NEELY E. WOODS

### 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Elsie Woods  
7. Birth date of deceased (mo., day, yr.) 9-25-10 6. (c) If alive, give age 37 years  
8. AGE: Years 37 Months 6 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Gaffney, S.C.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name Cornelius Woods

13. Birthplace South Carolina

14. Maiden name Susan Scott

15. Birthplace North Carolina

16. Informant Clinical Records, Ft. Howard, Md.

Address Fort Howard, Maryland

17. Shipped Date thereof 3/29/48  
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Gaffney S.C.

Location Baltimore, Md.

18. Funeral director Mrs. Katie R. Williams

Address 322 N. Schroeder St., Balto., Md.

19. 3/29 48 A.W. Hedrick  
(Date rec'd by registrar) (year) (month) (day) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 48 at 6:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 19 48 to March 25 19 48

and that I last saw him alive on March 25 19 48

Immediate cause of death TUBERCULOSIS, BILATERAL DURATION Unknown  
WITH CAVITATION LEFT LUNG

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Bronchopleural Fistula

Left. Empyema Left Chest Unknown  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A.W. St. Clair

A.W. ST. CLAIR, M.D. M. D. or other

Address V.A.H. FORT HOWARD, MD. Date signed 3-27-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

### 1. PLACE OF DEATH:

County Baltimore  
City or town woodlawn, 6746 Windsor mill Rd.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.  
Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6746 Windsor mill Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war 201

### 3.(a) FULL NAME

James Ferdinand younger

### 3.(b) Social Security Number

4. Sex m 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mrs. Clara R. younger

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1877 6.(c) If alive, give age 62 years

8. AGE: Years 71 Months 2 Days 13 If less than one day hrs. min.

9. Birthplace Baltimore Co. Md.  
(Town, county, and state)

10. Usual occupation Builder

11. Industry or business contracting

12. Name George younger

13. Birthplace Baltimore Co. Md.

14. Maiden name Katherine Bjerkly

15. Birthplace Baltimore Co. Md.

16. Informant Mrs Robert Lynch (daughter)

Address McDonough, Ind.

17. Burial Date thereof March 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olive Cemetery

Location Randallstown, Md.

18. Funeral director Billis Lauroan

Address 4510 Liberty Heights Ave.

19. 3/20/1948 H.A. Lwings  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 20 March 1948 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 July 1947 to 20 Mar 1948 and that I last saw him alive on 18 March 1948

Immediate cause of death cardiorespiratory failure DURATION 24 hrs.

Due to Bronchogenic carcinoma 1 yr

Due to It.

Other conditions none.

(Include pregnancy within 3 months of death)

Major findings of operations none.

Date of op. —

Autopsy results none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul H. Royce M.D. M. D. or other

Address Pikesville 8 Md Date signed 20 Mar 48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1948

BUREAU V. S.